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ORIGINAL ARTICLES.

THE PHYSICIAN.*

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As has been the custom, it becomes my duty, as retiring President of this society, to deliver before you the "Annual Address." And in attempting this it is certainly with a good deal of trepidation, knowing my unfitness for such an undertaking. The duties of the medical profession are not such as tend to develop the powers of rhetoric and oratory.

The physician is a man of deeds rather than of words; more accustomed to silent cogitations by the sick bed or in his office, as he notes the symptoms in the case before him and attempts to explain their cause, or as he decides upon the treatment best calculated to promote the recovery of the sufferer. He lacks the experience that comes to men in other professions, who take part in public discussions, or whose duties place them behind the pulpit, or upon the rostrum of the lecture room.

But if the physician is not a "good speaker," he is a "good hearer." The very training received in the investigation of disease, in the careful and minute observations and accurate interpretation of symptoms, educates his senses, and develops his powers of observation, making of him an attentive and critical listener, and hence, my greater timidity in coming before you.

But not to weary you with my apologies, allow me to say, by way of introduction, that the meetings of this Society are a "means of grace" that none of us can well afford to lose. We need the friendly associations of our fellow physicians. We need the mutual interchange of experience and opinions. None so learned but that he may be profited by these; none with so meagre an experience but that he may furnish a suggestion of value to others. Without these, we are liable to become narrow minded practitioners, to fall into ruts, to lose interest in our work, and its duties become the "tread mill" of our existence.

But more than this, our society relations tend to destroy the spirit of envy and jealousy that is so liable to arise among men engaged in the same calling. Instead, there prevails a spirit of peace and good will. We recognize the fact that we are a brotherhood whose end is to relieve suffering humanity; to make man physically stronger, and as a consequence, morally and intellectually better, because man's moral and intellectual attributes depend upon the development of his physical organization. Having therefore the common purpose, by our united efforts we are able to accomplish the greater good.

Another year of society work is done, and we have reason for congratulations that not one of our number has dropped out of practice by reason of death or failing health. We yet present an unbroken front, able and willing and anxious to do battle against disease. As we are about to enter upon a new year with its attendant

*Annual Address before the Butler County Medical Society by retiring President.

duties and responsibilities, would it not be well to take a retrospect of the past year?

Recall its failures and successes; take an inventory of our medical experience, that we may know whether or not we have been profitable servants to the well being of society? And as we come to render an account of our stewardship, is it with the pleasing satisfaction of knowing our faith pleases, in that our talent has gained other talents? Or do we come with fear and trembling, bringing the talent entrusted to us carefully preserved in a napkin, having failed to invest it with profit? We are under obligations to society, not only to protect and preserve the medical truths entrusted to us, but as we enjoy the records of the accumulated experience of generations of the past, so we owe to the generations of the future such a use of our advantages of experience as will add to the records of medical knowledge; else we deserve to be condemned as unfaithful and unprofitable servants.

We look back over the past, not with vain and foolish longings for its past advantages and pleasures, but because the past offers the only land marks by which our future is to be directed. Nathaniel Hawthorne makes a character in one of his stories to say, "Whatever we seek to do of our own free motion, a dead man's icy hand obstructs us." It is not true. This "icy hand" of the dead past is leading us into wisdom's ways. It is the finger-board that points us towards the haven of truth.

I might also have added, in the same connection he says, "We die of the same remedies with which dead doctors killed their patients."

We know nothing except as it is revealed to us by past experience. Scientific knowledge is founded upon this. We have been sneeringly called "empirics." Yet this epithet intended as a term of reproach, is most highly complimentary, as "empiricism" is a foundation of rock upon which is built the superstructure of science, and upon this the winds and rains of criticism and opposition have no effect.

"If," says Dr. Sam'l Johnson, "no use be made of the labors of past ages, the world must remain always in the infancy of its knowledge."

Experience is the wood and stone, the brick and mortar, the iron, the brass, the silver, the gold and the precious gems which the builder uses in the construction and decoration of the magnificent temple of "Eternal and Infinite Truth." We may not be the architect who plans and supervises the building. It may not be ours to fill the places of cunning and skilled workmen. We may be but humble hewers of wood or bearers of stone; but whatever part we take in this great work let it be done honestly, carefully, thoroughly, so that the storms of time will not overthrow it. And to this temple all future generations shall come to worship, because within its holy place dwelleth the Divinity of Truth.

But not only is it proper and profitable to review the past that we may glean knowledge from the fields of experience that have been harvested, but also that we may have a true appreciation of the profession to which we belong.

"Value yourself at what you are worth," was the saying of one whom I looked on as possessing great practical shrewdness. Value the profession at its true worth is a very praise-worthy egotism. As the veteran soldiers gather around their camp-fires and recount the deeds of military skill and courage of the past, and are thereby stimulated to daring acts of valor in the 'morrow's fight, so may we, by recalling the efforts of those heroes of the medical profession who in face of all opposition and discouragements have made valuable discoveries in medical science, be stimulated to renewed efforts in our warfare against disease, that new remedies and new methods of treatment be discovered, and the sufferings of mankind alleviated.

It is with excusable pride I point to the successes of the medical profession in the past, and comparing these with what has been done by other professions and in other callings, am ready to make this assertion without fear of contradiction. That the medical profession in the importance of its work, in what it has done to overthrow ignorance and superstition, and in the unselfishness of its charity, stands second to no other calling or profession. And I say this, with all respect to the honest and faithful efforts of others, knowing that we are all members of one body of which the eye cannot say to the hand I have no need of thee.

First, as to the importance of the medical profession. That we fully comprehend this, it may be necessary to consider what is the great purpose of our lives. What is the object of all labor in the various industries of the world? Why, the struggle to gain knowledge, wealth and honor? Are these the end of our existence?

It is possible to so lose sight of the chief end of life as to make of these the end, which are but means to an end. We acquire knowledge and wealth that we may live For this torrid heat and arctic cold are endured; the ocean's storms braved. For this rivers have been bridged, mountains tunneled, forests cleared, the wilderness made to blossom as the rose, and the barren desert to bring forth abundantly. All this that man may live. Let us emphasize this truth: *The great object of life is to live.* We are born with inherent desires for life. We are constantly struggling to overcome unfavorable surroundings, to understand the laws of nature, that by bringing ourselves into harmony with these, we may live. If then, the end of life is to live, that calling that has to do with man's physical organization must be of chief importance. The physician with scalpel and microscope studies the structure of the various organs of the body. By carefully conducted experiments he learns the functions of these parts. With like care he examines the structure of diseased organs, and notes their altered functions. He searches the animal, the vegetable and the mineral kingdoms for means to restore the diseased organs to a condition of health and normal function. But not only does he cure disease but, as a guardian of the public health, he instructs the people in those laws that govern their physical being, the observance of which promotes health and lengthens life. He selects the food best suited to further the growth and development of the body; he arranges the style and fabric of clothing; houses are built according to his plans. At his direction swamps are drained, waters are purified, sewers are laid, streets are swept, pools of contagion disinfected, and loathsome plagues eradicated. The surgeon's knife is no longer a thing of terror, and under the influence of anæsthesia, the offending member is removed and many valuable lives are saved. But why the further enumeration of these valuable services when the importance of the profession of medicine is so evident.

But again, no class of men have done more to overthrow ignorance and superstition, and among none others, do we find permitted the same freedom of investigation and discussion. We are not fettered by "ancient theories" or "old time dogmas," to which we must give unlimited credence. And rejecting these does not subject us to excommunication from the profession. We value the truth not because it is old, neither because of its general acceptance, nor yet because it has associated with it some marvelous story of supernatural revelation, but because it is truth and has stood the test of rational investigation.

We are perfectly free to reject a theory, notwithstanding its age and general acceptance, if it has been weighed in the balance of scientific medicine and found wanting. And for such rejection, we are in no danger of being brought before a tribunal of inquisition and condemned to professional death. Well for a sister profession did the same freedom of search after truth prevail. Witness the trial and condemnation of Briggs, who was crucified by his brethen, between Bob Ingersol on one side and Tom Paine's ghost on the other.

The medical profession has never been found stoning Stephen, burning witches, or hanging Quakers. Accused by the priesthood before Pilate, or doing God's service in hunting to the death those who dare to preach doctrines contrary to the accepted religion, is the history of all persecution.

And "Great is Diana of the Ephesians" has been the battle cry of superstition in all ages, as its votaries have waged their cruel and unrelenting war against science. As you all know the medical profession originated in the separation of medical truths from their union with the superstitions of priest craft. Primitive man, with no experimental knowledge upon which to base a theory of disease, looked upon the pain and sickness as indicating the wrath of the Deity supposed to have created man and having unlimited powers over the work of his creation.

To understand, and to be able to appease the wrath of this offended Deity, were attributes assumed by certain ones who, by working upon the credulity of

their fellows impressed these with a belief in such pretended supernatural powers. In this way was originated the priesthood or profession of theology. That the priests might retain their hold upon mankind, it was necessary, that in their treatment of the sick, these efforts should be attended with some degree of success, and this led to the study of the phenomena of disease, and means to cure this. Thus the first medical truths were associated with priest-craft and the priests were the first physicians.

But the practice of medicine by these priest-physicians was so mixed up with the rites and ceremonies, the offerings and incantations of their religion that the truth was hidden from the public gaze, and the cures effected were supposed to have been the result of supernatural agencies. About the year 450 B. C., when the learning of Grecian philosophy was at its height, Hippocrates effected the separation of which I have spoken, and medicine divorced from priest-craft has ever since maintained a separate existence, its followers recognizing Hippocrates as the "Father of Medicine." But even though more than twenty-three centuries have passed since then, and notwithstanding the great advancement of medical science, the ancient teachings of the priesthood have retained such hold upon the minds of men, that it is no uncommon thing to hear sickness spoken of as the mysterious ways of an inscrutable and all-wise Providence, and, also, to hear the Deity importuned to allay sickness; and in the minds of many, the visits of the clergy are as necessary to the well-being of the patient, as are the visits of the physician. Superstition has a mighty hold upon the world, and with its twin-sister, ignorance, obstructs the path of progress, and shuts out the light of scientific truth.

But not only is the medical profession of first importance to the well-being of society, and a champion and an advocate of the truth, but its followers are living examples of the principles taught by the "Peasant of Nazareth," who gave to the world the commandment of Love. "I was an hungered and ye fed me, naked and ye clothed me; I was sick, and ye visited me." Where is the class of men so faithful in the performance of their duties as physicians. The profession of medicine having for its end the common good of mankind, knows nothing of national enmity, political strife or sectarian dissensions.

It dispenses its benefits without stint to men of every country, party or religion.

The physician is the good Samaritan, who binds up the wounds of the man fallen among thieves, although a priest and a Levite had passed by without being touched by the sufferings of the unfortunate man. No other class of men dare as much, risk as much for the welfare of others. Men excited by the noise of battle and stimulated by the presence of hosts of comrades, have risked their lives in the performance of most wonderful deeds of valor. The physician with no thoughts of worldly applause, with no thought of the small pittance he may receive for his services, in the slums of vice and in the midst of the filth and wretchedness of poverty, exposes himself to the deadly contagion that the poor sufferer be relieved, or that the deadly epidemic be stayed. Such an one is a thousand times more a hero than he who faces the destructive fire of cannon and musketry. Men who have passed through the horrors of war without a thought of cowardice, stand with quaking hearts and blanched faces in the presence of contagious diseases, or flee for their lives from the plague-smitten district. While the physician goes about his work of caring for the sick with a cool head and a sympathetic heart, administering medicine to relieve their sufferings and cheering words of encouragement to relieve their despondency. A veritable angel of mercy to the poor sufferers. Not only to cure disease, but to prevent it as well. No labor is too hard, no risk is too great that the cause of disease be discovered and its ravages prevented. None are so poorly paid as the physician. Much of his work lies among the poor and vicious, who are sick because of their poverty and wickedness. To these he gives his time, and very often medicines. All of which are usually received in a sort of you-are-obliged-to-do-it spirit, and little thanks for his kindness.

Even in the minds of the general public, there prevails the notion, that the physician is under greater obligations to give his services without compensation, than are men in other callings.

The miller may refuse the flour, the butcher the meat, the merchant the clothing, that the poor family be fed and clothed. But let the physician refuse to visit this same family, such a hub-bub of righteous indignation is stirred up against him as no one would have the courage to face. The reason of this is the fact that such charity is very rarely withheld. The priest may refuse his blessing to the dying sinner. But none so vile that he may not receive the kindly offices of the physician who alleviates his pain without condemning his vice.

But what of all this. If these things are true, does not such an egotistic view of the profession of medicine and its value tend to fill us with an exalted sense of our importance? That in the haughtiness of spirit we cry out, is not this great Babylon that we have built? Not so. To realize all this, to value the profession at its true worth, impresses us with the greater responsibilities resting upon us by reason of the high character of our calling, whereby we have the greater opportunities for doing good. And we dare not neglect the voice of duty that comes mingled with the groans of sick and dying.

From the position we occupy, we are able to see the great things that have been done in medicine. But in the line of our vision is also to be seen very much remaining yet to be done. Epidemics sweep over our land, in whose wake are to be heard the lamentations of the mourners who sorrow for the loss of those fallen under the blightings of the deadly plague. Men and women are dying with diseases so loathsome in character as to make of them objects of dread and disgust to all around, while their bodies are racked with most excruciating pains. The physician stands by, powerless to stay the progress of the disease or to relieve the suffering it occasions.

In our cemeteries, as we read the inscriptions upon the stones that mark where the dead are laid, we find that but very few have reached the limit of man's existence. In infancy, in childhood, and in early manhood, the greater number have passed away. And this, not because a kind Providence has seen fit to remove them from the temptations and snares of a wicked world, but because the laws of hygiene have not been perfectly understood, because the nature of contagious diseases has not been discovered, and because we have not been able to eradicate the influence of heredity. Are there not great opportunities of usefulness for us in the fields of medicine, not only the more skillful application of those truths already known, but the discovery of new truths? Before us lies the ocean of investigation, upon which we may launch our barks upon a voyage of discovery. Already there are signs of our nearness to land. There comes floating towards us strange forms of microscopic life. We have picked up the "carved wood" of cell propagation and soon we may expect to take possession of this new world of unknown truths, upon whose shores we will plant the banner and cross of Medical Science.

Chloralamid a Remedy for Sea-Sickness.

Mal de mer is an ailment, to the treatment of which I directed attention at the recent meeting of the Medical-Climatological Section of your Exposition. I there stated that evidence very complete and very convincing, existed as to the utility of a solution of chloralamid and bromide of potassium, known as chlorobrom, in arresting the retching and in allaying the mental depression which accrues after the stage of active vomiting had passed. Since then evidence has been published in the *Lancet* by ship surgeons which notably proved its prophylactic action, if certain medicinal and dietetic requirements be carried out, previous to the passenger going on board ship. These requirements are simple, and need not now be mentioned. The solution is potent, palatable and safe. It is always retained, and I have no hesitation in saying that, at last, we have found a remedy for "The swooning sickness of the dismal sea."—*No. Amer. Practitioner.*

LONESOME.—The feeling of superiority in the sterner sex is inborn.

"Mamma, do you think you'll go to heaven?" said Jack, thoughtfully looking into his mother's face.

"Yes, dear, if I'm good," said the little mother, cautiously, wondering what would come next.

"Then please be good, for papa and I would be lonesome without you."—*Kate Field's Washington.*

COMMUNICATIONS.

THE HYPODERMIC INJECTION OF SULPHATE OF MAGNESIUM AS A PURGATIVE.*

J. PERCY WADE, M. D.,†

In 1873, M. Luton, made the statement, that ten centigrammes of Sulphate of Magnesium injected under the skin, regularly produced purgation. Claude Bernard had previously stated that when injected into the vein Epsom Salts produced a purgative effect.

These statements appear to attract but very little attention on the part of clinicians and slight notice is given to them in works on Therapeutics. However, Dr. Horatio C. Wood (Therapeutics; 8th edition, 1891; page 722) makes a slight reference to the former, although considering the practice a very doubtful one.

Dr. Matthew Hay, who has contributed so much to our knowledge of the physiological action of the saline purgatives, asserts that the Sulphates of Magnesium and Sodium do not purge when injected into the blood, or subcutaneously. In the latter case, he makes an exception in cases where in virtue of the injection a local irritation of the abdominal subcutaneous tissue is produced, "which acts reflexly on the intestines, dilating their blood vessels, and perhaps stimulating their muscular movement." Dr. Hay also states that when injected into the blood, Sulphate of Magnesium is powerfully toxic to the system, "paralyzing first the respiration and afterwards the heart and abolishing sensation, or paralyzing the sensory motor reflex centres."

The dose that M. Luton used, and found to act as an effective purgative was ten centigrammes, equivalent to 1.54 grains. Acting upon a suggestion of Dr. Rohé, the superintendent, to subject the question to a further clinical observation, forty-six patients were selected, who suffered from habitual constipation and required from 2 ozs. to 3 ozs., of a saturated solution of Magnesium Sulphate to produce one or more free movements of the bowels.

A two-per-cent. solution of Epsom salts in sterilized water was used. The hypodermic syringe employed had a capacity of two drachms, and when not in use, was kept in carbolized oil. Just previous to use, the needle was sterilized by steam. The dose varied from 1.86 grains to 4.5 grains. The smallest dose was first tried, and at each subsequent injection was increased one-half grain, in order to determine whether a slight increase in the dose would cause a free evacuation. It was found that the small dose acted as efficiently as the slightly larger.

In only one case was the largest dose (4.5 grs.) employed. This was a woman in whom 2 ozs. of a saturated solution of Magnesium Sulphate had previously failed to produce a movement. The subcutaneous injection caused a free evacuation in seven hours.

The site of the injection was the left arm, at the outer aspect midway between the elbow and the shoulder. In none of the cases was there any local reaction at the point of injection. A small swelling or slight tenderness was produced by the distension of the connective tissue which disappeared in a few hours. No induration or abscesses occurred, and the slight discoloration of the skin passed off in a day or two.

The injection was made 100 times in the 46 patients, and was successful 67 times or 67 per cent. and failed to act 33 times or in 33 per cent.

In 53 injections it produced one evacuation of the bowels; in ten, it produced two movements, and in four it produced three evacuations.

In only two patients were the injections a constant failure and both of the patients were of the class of melancholia with habitual constipation, who resisted nearly all purgatives.

In nine cases, the injection of 1.15 grs.—one-half the average dose—was repeated in one hour and caused two evacuations in five cases; in one, three movements; in two, one; in one, failed to act at all. This action shows that a small dose repeated in a short time has a better effect than one single dose of larger size.

In ten selected cases a comparison wa made between the hypodermic injection

* From advance sheets 96th Annual Report of Med. Hosp., for the Insane.

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2. Trousseau and Pidoux, Therapeutics, Vol. 2, Page 165. Wm. Wood & Co. 1880.

of Magnesium Sulphate and the exhibition of a saturated solution by the mouth. In seven cases, or 70 per cent., the injection produced free evacuation; whereas one oz. given by the mouth acted in only three or 30 per cent.

The shortest time for the injection to produce an evacuation was three hours; the longest fourteen hours—the average being seven hours.

As to the consistency of the stools—45 may be said to have been watery, resembling those produced by a free saline purgative; in 11 they were mucilaginous in character, and the remaining 11 were the ordinary stools.

No action was noticed upon the general system following the injection.

In 50 injections noticed ½ hour after the injection, no rise in temperature, pulse or respiration occurred.

The indications for the use of the drug by hypodermic injection are obvious. In cases of gastric inflammation, where a purgative is required and the stomach rebels; in abdominal surgery, where a purgative by the mouth is apt to cause vomiting and in cases where the patient is unconscious, and unable to swallow, as in apoplexy, the hypodermic use of this purgative would be valuable.

In none of the 46 cases did such indications arise, but the work was done as an experiment and to demonstrate the value of the drug as a therapeutic agent when given subcutaneously. No explanation is offered as to its physiological action. That it does act when so given is a fact.

The effect could not be attributed to suggestion, as the patients did not know with what object the injections were made; besides, insane patients are notoriously difficult to influence by suggestion.

As stated before, the injections were always made into the arm, so that the aid of reflex irritation, in the sense of Matthew Hay, cannot be invoked in explanation.

THE RELATION OF PELVIC DISEASE AND PHYSICAL DISTURBANCES IN WOMEN. SOME FURTHER OBSERVATIONS AND RESULTS.*

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In my report for 1892, I gave the detailed history of eighteen cases of insanity in women, in whom the uterine appendages were removed for ovarian, tubal or other pelvic diseases. Since that report four additional cases were operated upon. The following table gives a summary of the cases, together with the results in each case, to December 1, 1893:

A review of the cases will show that even in apparently the most hopeless cases, a beneficial effect upon the mental functions is obtained by the removal of a persistant source of local irritation. Thus in one case of hystero-epilepsy with violent maniacal attacks, lasting over eight years, complete recovery was obtained.

In four cases of puerperal insanity, two of over five years standing, three recoveries followed the operation, and the remaining case was greatly improved.

Three cases of profound melancholia recovered sufficiently to be discharged from the hospital.

In nearly every case operated on decided physical and mental improvement were noted.

While no claim is made that gynecological operations are generally indicated in insane women, it is held that where sufficient disease exists to demand treatment on its own account, the mental disturbance of the patient should be an additional reason for early and effective interference.

In the present conservative tendency among gynecologists, there is danger of delaying radical measures too long. If this delay is injudicious in the sane, as I firmly believe it to be, it is no less in the insane where recovery of mental health may be retarded or rendered impossible, by hesitancy or neglect.

I have been subjected to criticism, some of a rather savage character, for my work in this line. Some of my critics know, confessedly, little of the great advances made by modern gynecology, while others were no less ignorant of the results of recent studies of mental pathology. I have refrained from replying to these criticisms because I could afford to await results. The facts here presented will, I am sure, be regarded by all unprejudiced minds as sufficient answer to the criticisms upon my course.

*From Advance sheets from the Annual Report of the Maryland Hospital for the Insane, 1893.

Record of Operations upon Women with Pelvic Disease, in the

No. of Case.	Date of Admission.	Duration of Insanity at time of Admission.	Age.	Social Condition.	Form of Insanity.	Local Disease.
1	Dec. 19, 1886.	Second attack. Ten weeks.	33	Married.	Puerperal mania.	Lacerated cervix. Ruptured perineum. Adherent ovaries.
2	May 21, 1890.	Four months.	32	Married.	Melancholia.	Lacerated cervix.
3	Feb. 26, 1890.	Three months.	39	Single.	Hysterical mania.	Anteflexio uteri, firm adhesion of right ovary and tube.
4	Mar. 2, 1891.	Three months.	31	Single.	Melancholia.	Enlarged ovaries.
5	Oct. 5, 1891.	One week.	30	Married.	Melancholia.	Cystic and adherent ovaries.
6	Oct. 12, 1891.	One year.	29	Single.	Simple mania.	Retroversio uteri, adherent ovaries.
7	May 16, 1890.	Second attack. Three days.	37	Married.	Puerperal mania.	Lacerated cervix, adherent ovaries.
8	Mar. 30, 1885.	Unknown.	23	Married.	Hystero-Epilepsy with mania.	Cystic ovaries.
9	Aug. 23, 1887.	Four months.	39	Married.	Puerperal mania.	Lacerated cervix, adherent ovaries.
10	Apr. 4, 1890.	Epilepsy. Ten years.	25	Single.	Epileptic insanity.	Ligamentary cyst size of an orange.
11	Oct 22, 1888.	Three months.	24	Single.	Melancholia.	Cystic ovaries, and congested and tortuous tubes.
12	July 11, 1891.	Epilepsy. Seven years.	23	Single.	Epileptic insanity.	Double pyosalpinx and ovarian abscesses.
13	Dec. 28, 1891.	Third attack. Three days.	28	Married.	Puerperal mania.	Ruptured perineum. Enlarged and prolapsed ovaries.
14	Feb. 22, 1892.	Ten months.	43	Single.	Melancholia.	Cirrhotic ovaries.
15	Apr. 12, 1892.	Epilepsy. Nine years.	24	Single.	Epileptic insanity.	Cystic ovaries.
16	Oct. 31, 1882.	Two years.	30	Single.	Periodic mania.	Cystic ovaries.
17	May 14, 1892.	Two years.	29	Widow.	Paranoia.	Cystic ovaries. Trachelorrhaphy had been done for lacerated cervix.
18	June 7, 1892.	Five years.	30	Married.	Periodic mania.	Lacerated cervix, retroflexio uteri, cystic ovaries.
19	Sept. 12, 1892.	Two years	30	Single.	Hysterical mania.	Retroverted and adherent uterus, cystic ovaries.
20	Nov. 3, 1892.	Two years.	23	Married.	Melancholia.	Retroversio uteri, lacerated cervix, cystic ovaries.
21	June 11, 1891.	One year.	17	Single.	Periodic mania.	Enlarged ovaries and tortuous tubes.
22	May 26, 1893.	Five years.	40	Married.	Hystero-Epilepsy with mania.	Firmly adherent ovary on right side. Ovary and tube of left side absent. Ventral hernia from a previous abdominal section.

Maryland Hospital for the Insane, with Results to Dec 1, 1893.

Date of Operation.	Operation.	Immediate Result.	Ultimate Result and Remarks.
Oct. 6, 1891.	Removal of uterine appendages; restoration of perineum; trachelorrhaphy.	Recovery.	Decided mental and physical improvement. Recently phthisis developed, under which she is rapidly losing ground.
Oct. 13, 1891.	Removal of the uterine appendages.	Recovery.	Physical improvement. No mental change.
Oct. 21, 1891.	Removal of the uterine appendages.	Recovery.	Decided physical improvement. No noticeable mental change.
Nov. 4, 1891.	Removal of the uterine appendages.	Recovery.	Decided physical and mental improvement. Patient at nine months nearly well.
Nov. 4, 1891.	Removal of the uterine appendages.	Recovery.	Physical and mental improvement. Patient discharged from Hospital October 1, 1893. Four weeks later she was run over by a railroad train. This may have been a case of suicide, but there is no evidence of this.
Nov. 10, 1891.	Removal of the uterine appendages.	Recovery.	Physical improvement. Slight mental improvement.
Nov. 25, 1891.	Removal of the uterine appendages.	Recovery.	Physical improvement. Mental recovery. Discharged recovered August 21, 1892. Remains well December 1, 1893.
Dec. 10, 1891.	Removal of the uterine appendages.	Recovery.	Discharged entirely recovered May 12, 1892. June 30, 1893, she had two hysterical attacks, following accidental death of a relative. She was kept under observation three weeks without any return of the attack. December 1, 1893, she remains entirely well.
Dec 15, 1891.	Removal of the uterine appendages.	Recovery.	Great physical and mental improvement. Patient from being one of the worst and most troublesome cases in the Hospital improved so much that she could be discharged from the Hospital November 28, 1893.
Dec. 30, 1891.	Removal of ligamentary cyst and uterine appendages.	Death.	Died in status epilepticus. Probably septicæmia.
Jan. 19, 1892.	Removal of the uterine appendages.	Recovery.	No mental change.
Feb. 9, 1892.	Removal of the uterine appendages.	Death.	Died of Septicæmia.
Mar. 9, 1892.	Removal of the uterine appendages.	Recovery.	Discharged entirely recovered May 8, 1892. December 1, 1893, remains well.
Apr. 20, 1892.	Removal of the uterine appendages.	Recovery.	Decided physical and mental improvement.
May 12, 1892.	Removal of the uterine appendages.	Recovery.	Convulsions less frequent but still persist. Slight mental improvement.
July 14, 1892.	Removal of the uterine appendages.	Recovery.	Very decided mental improvement.
Aug. 30, 1892.	Removal of the uterine appendages.	Recovery.	Improved considerably, but was removed from Hospital, and is now reported worse.
Sept. 12, 1892.	Removal of the uterine appendages.	Recovery.	Decided mental improvement, which continues.
Dec. 1, 1892.	Removal of the uterine appendages.	Recovery.	No mental change.
Jan. 19, 1893.	Removal of the uterine appendages.	Recovery.	Complete physical and mental recovery. Discharged April 1, 1893 Remains well, December 1, 1893.
Feb. 2, 1893.	Removal of the uterine appendages.	Recovery.	Decided progressive mental improvement.
Oct. 26, 1892.	Removal of ovary and tube on right side.	Recovery.	Operation too recent to give ultimate result.

REPORT OF CASE OF ABSCESS OF THE BRAIN.

R. L. JOHNSON, M. D.,† Rolla, Mo.

In bringing before you a description of a single case of abscess of the brain, I have the consciousness that although it may lack in detail, there is nothing added to embellish it—that it is not written either to establish or to conform to any theory of pathologist or surgeon, but as an offering of facts. It is only by observing and reporting facts accurately, that data are accumulated, from which general principles are deduced. No one surgeon has in his life enough cases of abscess of the brain to furnish all the data needed for the thorough establishment of rules of treatment. Therefore it becomes the duty of every practitioner to observe carefully and report accurately all cases coming under his observation. This becomes all the more a duty when we remember that these opportunities always imply suffering and risk of human lives and should, therefore, be carefully economized.

That rules of treatment are not thoroughly established, I find from the recent literature of the subject and also from conversation with a good friend of mine, an eminent surgeon in this city, who kindly told me I had not treated my case in the most approved style; for this I expressed my regrets, for had I done so, I might have been able to make my report more complete, by giving a description of the *post mortem* appearances.

On November 5th 1892, I was called to see William M. aged fifteen years.

History and subjective symptoms:—I was told that he received a blow upon the head, from an old lime-encrusted white wash brush, thrown at him, which had knocked him senseless for a while; that he had a slight dull headache and was somewhat constipated, and that he had been feeling badly for several days. I was only told of this accident after I had decided that he was suffering from a torpid state of the liver and bowels. Upon a careful examination of all objective symptoms, I found a slight depression an inch posteriorly to the external angular process of the frontal bone, a half an inch in length, over the portion contiguous to the sphenoid; the skin was not broken at all; the tongue was large and furred; his pulse rather slow and the temperature normal; he was dull and slow of speech, but perfectly intelligent; there was entire absence of paralysis, motor or sensory; his sight was good and the pupils responded equally and promptly to light. I gave a purgative and advised quiet for a few days and requested to be notified if he did not get well promptly. During the next two weeks he was not seen; he was at work—hard work—hauling stone. At the end of that time, after hard riding horseback, headache, which had troubled him some, became rather severe; he was given potassium bromide freely, which relieved it to a great extent. On the 30th, and on the 1st, 4th, and 9th of Dec., I saw him and found him getting thin; his tongue coating more and more; his countenance dull and heavy, his speech slow, cerebration perfect but slow, answering questions slowly but correctly; headache most of the time; there was no fever at any time. Although his countenance and general appearance suggested typhoid fever, there was never any rise of temperature or increased frequency of pulse. On the 15th his pulse was below sixty and halting, a hesitating pulse; his bowels would not move without an active cathartic; no paralysis; pupils always responsive. On the 15th I insisted on consultation with reference to trephining. Dr. T. J. Jones agreed as to the necessity of the operation, and Drs. Rowe and Carpenter were invited to be present and kindly assisted me.

A Y-shaped incision being made in the scalp, the trephine was applied to the frontal bone just below the temporal ridge and at a point corresponding internally with Broca's convolution. On attempting to elevate the depressed portion, it was found to be much comminuted, the fragments setting nearly at right angles to the plane of the skull; these fragments were carefully removed and the sharp edges of the skull were rounded off, the dura mater, which was was not torn and which was of a dark-red color, slowly rose up to its proper level, but did not bulge into the opening at all. To the touch it felt softer

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than the brain, suggesting the presence of some fluid under it, but it was neither tense nor elastic. On consultation it was not deemed advisable to open it then as it could be done afterwards if he was not relieved. After the operation his general condition improved for a day or two; he became more cheerful and looked better, having lost the listless apathetic countenance. His pulse, however, continued as slow as before and his bowels remained constipated. On the night of the 19th, four days after the operation, it was observed that he did not use his left hand, which was not completely paralyzed, however, but so feeble that he could scarcely move it, while his grip was almost imperceptible. Paralysis of the left side of the face was now marked. Patellar reflex was absent (this was the case before he was trephined.)

There is now also a partial paralysis of the left leg. The pupils remain responsive to light. There has never been any impairment of vision or of power to move the eyes. On the 20th I opened the incision, which had healed by first intention, for about half an inch and pressed with the end of the grooved director upon the dura mater, and was satisfied that it was now tense and elastic. I then used a fine trocar and canula twice the size of a large hypodermic needle, pushing it downwards and slightly backwards (as he lay) one and a half inches before I reached pus. I then pushed in a straight bistoury and upon turning it pus flowed freely—"laudable pus." While it was flowing a rubber drainage tube was inserted one and a half inches into the wound and the pus continued to flow through and by it. The amount was estimated at three ounces, but it was not measured as it ran out freely on cloths and into the basin. The wound was dusted with iodoform; a thick compress of sublimate gauze was bound on; the drainage tube was brought through an opening in the compress and the end overlaid with sublimate cotton, and over all parafine paper. The relief from the operation was prompt. Before the opening of the abscess the pulse was forty-eight, and he appeared deaf and would neither answer nor move. In fifteen minutes he was reviving, and before I left the house, about an hour, he was smiling and talking freely and promptly. By the afternoon a remarkable change had taken place, instead of a shrunken, pale countenance he had some color; his lips were full and red and his pulse had gone up to eighty. The next day I attempted to syringe the abscess with a siphon, but there appeared to be but a very small cavity, some small clots, a little pus, and what appeared to be lumps of soft, broken down brain tissue. The next day only a little pus and bloody serum came away when I removed the tube, which I replaced. A few days after, as there was no discharge through the tube, I dilated the opening with a grooved director and got a teaspoonful of pus. From that time there was no further trouble of any kind; his pulse fluctuated from 65 to 82; he had no fever. Sordes, which I forgot to mention, cleared off; his tongue cleaned; his appetite became good and his bowels moved regularly without the aid of a cathartic. The changes in his physical condition appeared as remarkable as those in his nervous and mental phenomena. He rapidly progressed to perfect recovery and is now, one year after, at regular labor and apparently well, physically and mentally.

THE latest scare in microbes has been started by Professor Uffelman, of Rostock, who infected a letter with cholera bacilli, and put it into a post bag. When the letters were taken out, twenty-three and one-half hours later, the bacilli were still there. Bacilli were also found living on post cards twenty-four hours after infection. The micro-organisms were found to die rapidly when placed upon coins. A fly charged with cholera bacilli was afterwards placed on some beef. A little later the meat was found to be swarming with bacteria.—*Scientific American.*

WHEN a glass stopper sticks in the bottle, pass a strip of woolen cloth around the neck of the vessel and seesaw it backward and forward. This friction heats and causes the neck to expand, so that the stopper becomes loose. On this principle of expansion by heat a tight screw may be drawn from a metal socket with a cloth dipped in boiling water.—*Scientific American.*

THE truly great physician is one who never speaks ill of his medical brother. He is dead.—*Medical Record.*

A STUDY OF THE URINALYSES OF 110 CASES OF INSANITY*

ADMITTED TO THE MARYLAND HOSPITAL FOR THE INSANE FROM NOVEMBER 1, 1892, TO OCTOBER 31, 1893.

WARREN L. BABCOCK, M. D.,† CATONSVILLE, Md.

The systematic examination of the urine of the inmates of our public asylums and hospitals is a feature in diagnosis that has heretofore been neglected by the great majority of our asylum physicians. In those Hospitals where the examination of the urine, both chemical and microscopical, has been performed as a routine practice, the results have demonstrated the wisdom of the procedure. It is an unquestionable aid to a comprehensive diagnosis in many cases; a practice of precaution enabling the physician to adopt prophylactic measures before grave symptoms occur to warn him of the necessity for immediate therapeusis.

Much unfavorable comment has been elicited from those interested in urinary anomalies, by the fact that the physicians of our insane hospitals have persistently neglected the study of the urine of their patients.

About two years ago, Bondurant of the Alabama State Hospital, who has long insisted on a more comprehensive study of this subject, especially in its relation to Bright's disease, addressed a circular letter to Asylum Superintendents thoroughout the country, endeavoring to ascertain how many insisted on the examination of the urine of all cases admitted. He found to his surprise that only about a half-dozen in the country, made any effort towards a general examination of all cases admitted and that the great majority gave little attention to the subject, except in cases where the symptoms pointed to kidney disease and an examination of the urine seemed necessary to verify the diagnosis.

The writer has been unabled to find on record a single investigator who has written on the general subject of urinary anomalies of the Insane. It is true that a few have studied the causative relation of Bright's disease to insanity and reported isolated cases exhibiting urinary anomalies in general paresis and epileptic insanity, yet no reports have been recorded of a general chemical urinalyses of the insane.

In the tables given below efforts have been made to bring out all features of interest, both from a clinical and a chemical point of view, and notes have been made of all unsual cases. Abnormal ingredients and normal ingredients in excess will be briefly discussed and the clinical history of some of the cases presented by way of comparison with similar cases reported from other sources.

ALBUMEN. Considering each abnormal ingredient in the order of its clinical importance, albumen presents itself chief and foremost among those to follow.

The frequency of Albuminuria among the insane is a much disputed question. The reports recorded by writers on this subject are very contradictory to each other. Recent investigators, among them Dr. Christian of the Eastern Michigan Asylum,[1] Dr. Alice Bennett of the Norristown Asylum,[2] Dr. Tuttle of McLean, (Mass.) Asylum[3] and Dr. Bondurart of the Alabama State Hospital,[4] conclude that Albuminuria is very frequent among the psychoses and that bright's disease is a very prominent etiological factor in the production of insanity.

The last mentioned observer who has made a close study of the subject examined 1336 cases of various forms of insanity and found albumen in about 19.5 per cent. of all cases examined.

Dr. Amelia Gilmore of the Philadelphia Hospital for the Insane,[5] says that 25 per cent. of the admissions to the female department of the hospital give evidence of kidney disease by the presence of albumen and casts in the urine.

* From advance sheets of Hospt. Reports for 1893.

†Clinical Assistant, Maryland Hospital for the Insane.

1 Journal of the American Medical Association, March 23, 1889.

2 Alienist and Neurologist, Vol XI, No. 4.

3 American Journal of Insanity, April, 1892.

4 Journal of Mental and Nervous Diseases, November, 1892.

5 Journal of Mental and Nervous Diseases, August, 1893.

Only 9.9 per cent. of all cases admitted to the Maryland Hospital for the Insane during the past year had albuminuria, either of the pregnant or transient nature.

The variation in the percentage of cases affected, as reported by the observers quoted above, is explainable on the grounds that some forms of insanity contain a higher percentage of albumen in their urine, than others, and that the cases admitted and examined were plentiful in those varieties of mental disorder that are marked by the greater or less frequency of albuminuria.

On consulting table No. 2, on another page, it will be seen that the highest percentage of albumen was found in mania (12.1 per cent.) and epileptic Insanity (20 per cent.). These results are in accordance with those of many other observers but directly opposite those of Dr. Tuttle, as reported in the afore-mentioned paper. He finds his highest percentages in melancholia (40.2 per cent.) and general paresis (40 per cent.); compared with my results of 7.4 per cent. for the former and a total absence of albumen in the latter. This total absence in general paresis may be accounted for by the fact, that with one exception the urine was examined during the first stages of the disease. His conclusions in dementia agree with mine, both tables showing a trifle over 5 per cent. of cases of albuminuria.

Dr. Max Koppen[6] "finds that the presence of albumen in the urine of the psychoses apparently depends on the height or degree of the delirious element in the disorder."

Furstner, quoted by Tuke, found albumen in the urine of all cases of delirium tremens and demonstrated that the amount was directly proportioned to the intensity of the delirium.

My observations are directly in accordance with the above statements.

Thus it is found most frequently in acute and acute delirious mania and all psychical states attended with delirium whether of centric, excentric or toxic origin. Delirium is essentially an aggregation of psychical manifestations of a reflex nature, attended with exhausting symptoms, such as insomnia; anorexia; great restlessness and often slight fever, altogether presenting all the factors essential to increased tissue waste. The kidneys, overworked by increased elimination, undergo structural changes which are enhanced in degree by the high vascular tension and the arterial changes consequent on impoverished nutrition.

The highest percentage of albumen in the list was found in epileptic insanity (20 per cent.). The specimens examined were taken at random and usually during the interval between the paroxysms. By repeated examinations in one case it was noted that the amount of albumen was materially increased directly after the paroxysm.

Huppert[7] goes so far as to claim "that albumen appears in the urine of every epileptic soon after the paroxysm and that the amount depends on the severity of the convulsions."

Voison and Perron[8] found albumen in 50 per cent. of cases of "grand mal" and 100 per cent. of cases of status epilepticus.

In opposition to the above statements, Dr. Wm. Browning,[9] in an article on the epileptic intervals says "any special frequency of albuminuria in epilepsy has been disproved."

My examinations have convinced me that albuminuria is very frequent among the epileptic insane and that the amount of albumen passed with the urine is, in most cases, directly proportioned to the frequency, duration and intensity of the paroxysms.

The physical symptoms of the ten cases containing albumen vary greatly. Three of them are evidently chronic interstitial nephritis as shown by the following brief clinical histories.

No. 7. Mrs. E. A. F., aged 55 years, recurrent mania. When admitted in Dec. '92 was unable to walk. Physical examination revealed apparent cardiac dilatation with compensatory hypertrophy; cardiac mitral regurgitant murmur; atheromatous vessels; abdomen enlarged and distended with fluid; lower limbs œdematous and varicose, their surface covered with chronic superficial ulcers, and liver enlarged. One week after admission laparotomy was performed by Dr. Rohé and the hospital staff. Two gallons of fluid was evacuated from the peritoneal cavity.

6 American Journal of Insanity, Vol. XLVI, No. 1.

7 Tuke's Psychological Medicine, Page 1348.

8 American Journal of Insanity (abstract), Vol. XLIX, No. 1.

9 Journal of Mental and Nervous Diseases, Vol. XVIII, No. 7.

Recovery complete with improved mental condition. Albumen still present in small quantity.

No. 32. Mrs. E. K., aged 75 years, dementia. Plethoric habit; lower limbs œdematous; atheromatous arteries; hypertrophied heart and high arterial tension. Albumen constantly present.

No. 98. John J. D., aged 78 years, senile dementia. Died two months after admission. Urine contained both albumen and sugar. Specific gravity 1043. This case was unusually interesting from a pathological standpoint. It will be further discussed under the caption of sugar on another page. The post-mortem notes read as follows:

KIDNEYS. Both enlarged and very firm; cortical substance much diminished; capsule adherent; large cyst on right kidney containing three ounces of fluid; smaller cyst on left organ.

HEART. Greatly hypertrophied, especially the left side. Valves normal. Calcareous plates in aorta; and evidence of general arterio-sclerosis. The other cases present no special features of interest. No. 45 is a case of lactational insanity in which the albumen disappeared as improvement ensued. No. 91 is a case of epileptic insanity which presents the usual features of this form of insanity. Nos. 8, 10 and 66 are apparently cases of the so-called "Albuminuria of Adolescence," or as termed by other writers "Cyclic Albuminuria." These three cases closely resemble each other, the amount of albumen being slight and variable in quantity in each. The specific gravity, color and quantity of urine passed daily closely approximates the normal. The remaining two cases can doubtless be classed among those known as functional or intermittent albuminuria. Neither manifest any other symptom of kidney disease than the occasional presence of a slight quantity of albumen in their urine.

SUGAR. Sugar was found in the urine of four of the 110 cases. This high percentage (3.6 per cent.) is largely in excess of the frequency of glycosuria among the sane. The tests used to demonstrate its presence were: Fehling's and Haines' cupric sulphate; Boettger's bismuth; and the Picric acid test.

Several manifestations of the psychically diseased readily account for the fact that diabetes is a frequent concomitant of insanity. Among the most prominent may be mentioned the following:

A. Nutrition disturbed.

Prolonged and intense mental excitement and emotional disturbance, insomnia, anorexia, the ever varying physical strain that the mentally diseased economy undergoes, causes disturbed and impoverished nutrition as well as nervous degeneration in cases which are usually of a neurotic temperament from heredity.

B. Organic cerebral disease.

The special frequency of gross cerebral disease in the psychoses. Glycosuria due to disease of the brain is often met with in hospital practice. Frerichs collected thirty cases of brain disease giving rise to the excretion of sugar in the urine. Injury or tumors of the medulla in man and animals have demonstrated that a diabetic centre exists in the medulla near the floor of the fourth ventricle. Bernard located its exact position by a few well executed experiments on animals. Recklinghausen quoted by Tuke found sugar in the urine of a case of tumor of the floor of the fourth ventricle and Dompeling, quoted by the same authority, in a case of tumor of the pons and upper third of the medulla.

C. Congestion of the nervous centres.

The great motor restlessness of the maniacal insane is thought to be due to congestion of the motor tracts of the cord and motor centres of the brain. Pavy claims that the close proximity of the Bernard's Diabetic centre in the medulla to the over-functioning motor tracts would lead to stimulation of the latter, and the appearance of sugar in the urine. Diabetes due to this cause differs from that originating in disordered nutrition by the absence of progressive emaciation, voracious appetite, intense thirst and rapid course.

Judging from the frequency, in insanity, of these three-mentioned factors in the etiology of diabetes, it would seem that Glycosuria would be a frequent concomitant of mental disorder. My analysis of 110 cases seem to show that diabetes is 50 per cent. more frequent among the insane than any other class of the population. A more extensive urinalysis is necessary before any definite statement can be made on this subject.

The mean specific gravity, of the urine, of the four cases mentioned, was 1038.5.

Briefly analysing these cases, we find them as follows :

No. 59. M. J. K., aged 50 years; Acute Mania; physical health good. Urinalysis during the mania revealed the presence of sugar in large quantity, and a specific gravity of 1048. On subsidence of the mania sugar disappeared and has not since returned. The glycosuria in this case was doubtless due to the last-mentioned cause enumerated above, namely, temporary congestion of Bernard's centre in the medulla, and tends to advance the latter theory as a common cause of transient glycosuria among the insane.

No. 98. John J. D., aged 98 years. (See case No. 98 above).

The only symptoms of diabetes in this case was the presence of sugar in the urine. His physical health was good and his body well nourished. The post-mortem clearly demonstrated that the glycosuria was of cerebral origin. The brain was found to be of average size and weight; dura was adherent to calvarium; ventricles enormously dilated and filled with fluid; the floor and sides of the fourth ventricle were infiltrated and greatly thickened; right temporo sphenoidal lobe softened and broken down; frontal lobes atrophied, especially the right, which was marked on the surface by a recent hemorrhage; medulla soft and anemic. The presence of sugar in the urine of this case was apparently due to the involvement of the diabetic centre in the infiltration of the floor of the fourth ventricle, together with the apparent degenerated condition of the medulla.

The other two cases (Nos. 119 and 120) present no special features of interest.

It will be noted by a reference to the tables that two cases (Nos. 35 and 99 in the column under sugar are marked with an interrogation point. On examining the urine of these patients for sugar with the Cupric Sulphate tests, the reaction indicated a large quantity of sugar. Boettger's bismuth and the picric acid tests failed to verify this fact, and other reducing agents were indicated as the probable cause of the reduction to cupric oxide. The presence of chloral in the urine of these patients, was suggested by the fact that they both were taking or had recently taken bromidia, which largely depends on chloral for its sedative action. Witthaus [10] says that when taken continuously or in large doses chloral appears in the urine, and acts toward the cupric sulphate tests similarily to sugar. In fact many chemists use Fehling's solution as a test for chloral, in instances where the co-existence of sugar is negated.

PHOSPHATE IN EXCESS. An excess of earthy phosphates was found in 15.4 per cent. of all cases chronicled. These cases were so distributed throughout all varieties of insanity that few inferences can be drawn from its presence. Some writers have attempted to show the especial frequency and significance of an excess of earthy phosphates in cases of general paresis. It was present in 16.6 per cent. of my cases. This low percentage, compared with the greater frequency reported by other observers, I account for as follows: Of the six cases examined, all were in the first stages of the disease except one, and that single patient was the only one whose urine contained an excess of phosphates. Therefore I am inclined to the view that earthy phosphates do not appear in excess in general paresis until the latter stages of the disease, when decline is rapid.

URATES IN EXCESS. Urates in excess were found in 6.2 per cent. of all cases examined. The murexide test was used to demonstrate their presence. Of the seven cases containing urates, four or 52.2 per cent. were found in the manias. I can find no literature on this part of the subject, therefore no significance regarding its especial frequency in mania can be drawn until a series of cases are reported

BILE PIGMENT. Bile pigment was found in the urine of two female patients (cases Nos. 41 and 45) and its presence could not be accounted for from a physical standpoint, as both patients were in fair health at the time the examination was made. Gmelin's and Ultzmann's tests were used to demonstrate its presence.

Both patients were taking iron daily when the examinations were made, and in the absence of other causes, that fact I consider sufficient to account for its presence. To demonstrate this view, the administration of iron was temporarily discontinued in one case, and after the lapse of one week the urine again examined for bile pigment. As anticipated no bile was found on repeated examinations.

10. Manual of Chemistry, page 202.

That the iron caused an increase in the hæmoglobin of the blood and the latter a corresponding increase in the amount of bile pigment seems evident, the excess of bile pigment being eliminated with both fæces and urine.

SPECIFIC GRAVITY. The average specific gravity of the urine of the 110 cases was 1024.5, that of the females being 1023.5, while that of the males was 1025.5.

Dr. Gilmore, in the paper mentioned in another part of this article, says that urine of low specific gravity is most frequently found among the insane. My tables show that the mean specific gravity is much above the normal and varies according to the variety of insanity examined. In order that these cases may be readily studied I subjoin a table giving the average specific gravity of the urine of the several varieties of insanity.

Compared with the above, Tuke reports of the examination of the urine of 248 cases of insanity from the Bethlem Asylum. He found the mean specific gravity in cases of Mania to be 1026, of Dementia 1020, of Melancholia 1025, and of General Paresis 1021. The mean specific gravity of 248 cases examined was found to be 1025.5 while that of my series of 110 cases was 1025.6.

Rigby, quoted by Tuke, found a high specific gravity (1030) in the urine of Melancholiacs and a low specific gravity (1015) in the urine of cases of Dementia.

Thus it seems fairly demonstrated that the amount of normal and abnormal solids in the urine of the insane is over and above the total amount present in the urine of those who enjoy mental health, instead of below the normal as reported by a few observers.

SPECIFIC GRAVITY TABLE.

	Mania.		Melancholia.		Consecutive Dementia.		Senile Dementia.		Paranoia.		General Paresis.		Epileptic Insanity.		Hystero-Epilepsy.		Totals.
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Normal	0	5	1	2	0	1	0	1	0	0	0	0	1	0	0	0	11
Below Normal	1	1	2	5	2	7	1	0	0	1	0	0	1	0	0	0	15
Above Normal	10	16	12	5	6	7	3	5	10	0	6	0	3	0	0	1	84
Totals	11	22	15	12	8	9	4	6	10	1	6	0	5	0	0	1	110
Average	1027.7		1022.3		1024.5		1027.4		1019		1028		1026		1030		

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MRS. CLANCY.—"Yis, Mrs. Muggins, Pat and Oi part to mate no more. Oi went to the hospital to ax after him. 'Oi want to see me husband,' sez Oi—'the man that got blowed up.' 'Yez can't,' sez the docther—' he's under the influoence of Ann Estheticks.' 'Oi don't know the lady,' sez Oi, mighty dignified loike; 'but if me lawful wedded husband kin act like that when he's at dith's door, Oi'll have a divorce from him!'"—*Ex.*

SIR BENJAMIN RICHARDSON, in an address on "Athletic Life," says that abstinence from alcoholic fluid is absolutely necessary. "As long as you are in course of training, don't touch the hurtful thing. It will undermine all the qualities on which you depend for success, will injure your precision, your decision, your presence of mind and your endurance."—*Pub. Opinion.*

SOME INTERESTING SURGICAL CASES.

MARIE B. WERNER, M. D., PHILADELPHIA, PA.

I desire to report these surgical cases and study the tumors, because they present some particularly interesting features.

CASE I.—A multiple fibroid, very readily diagnosed by the many irregular nodules, clustered around the main tumor. The patient, who was sent to me by Dr. Ella S. Webbs, of Oxford, Penn., had suffered from hemorrhages and the usual pressure symptoms, all of which made it impossible for her to work; the result of the operation was all that could be desired.

These tumors are sometimes benefited by the simple removal of the ovaries and tubes, with the hopes of depriving it of its nutrition and inducing thereby a shrinkage of the mass, as well as permature menopause. This treatment was adopted after observation had taught that natural menopause had sometimes induced a cure. In this case the ovaries were so bound down that it became necessary, in order to give the desired relief, to remove the entire mass.

The operation of hysterectomy in this special class of fibroids has two important advantages; by the removal of the entire uterus, the patient no longer is in danger of any retrograde (sarcomatous) changes which, we know, often take place in this abnormal tissue; and again where there are fibroids near the mucous surface which even after careful and complete removal of the appendages have given rise to dangerous hemorrhages and necessitating further operative procedure.

CASE II.—Gives us evidence that fibroid tumors of the hard variety may grow even after the menopause has been established.

The patient was sixty years old, had five children, no miscarriages and passed the menopause at the age of fifty-two. There was no flow for two years, when suddenly a profuse hemorrhage occurred, which was repeated in a few weeks. An examination revealed an enlarged globular uterus and a small atrophied cervix; the fundus of the uterus reached a little below midway between the pubis and umbilicus. Various medicines and treatments were used, with but partial success. The intervals between the hemorrhages were longer, but the loss of blood was more profuse; in fact, on one occasion the loss in a half hour was so great as to produce syncope. The hemorrhages came on without pain or warning. In one instance the patient was sitting on a chair and remarked that she must have sat in water, but upon looking found that a hemorrhage had suddenly come on, her clothes and the floor were stained with blood; in the recumbent position it was scarcely possible to feel her pulse for some time. This was about the last severe hemorrhage before the operation. She felt that she was getting weaker, and was beginning to feel unable to attend to her household duties as formerly.

An examination showed that the mass had grown to about twice the size it had been on a previous examination, two years before. It was wedged down in the pelvis and almost on a level with the umbilicus. After consultation with Dr. J. Price, the patient, herself, fixed upon the time of operation, which was performed in January,'93, after some time of preparatory treatment. Assisted by Dr. J. Price, I removed the tumor which was wedged down in the pelvis, adherent in some places, the ovaries and tubes, particularly the right tube, being supplied with immense blood vessels.

In making the stump, we found the cervix, as well as the whole uterine cavity, filled with a soft spongy mass, suggesting cancerous changes. Closer investigation of the tumor, after the operation was completed, revealed a very large uterine cavity, the distance between the two cornua being six inches, not including that part of the canal inclosed in the stump. The anterior wall of the uterus was thin enough to give the definite outline, externally, of the finger within the cavity, suggesting the danger of the use of intra-uterine electricity or the curette, both of which, with a solid resisting tumor in the posterior wall would have found a ready exit, after the exercise of even a moderate amount of pressure, with an unavoidable resulting peritonitis. Again a careful examination of the tumor will show you the enormous blood vessels, especially near its mucous surface, their open mouths showing the daily danger of a fatal hemorrhage. This tumor, without doubt one of the hard variety of fibroids, increased in size during

the last four years. We are taught, and various operators have agreed, that the simple fibroid ceases to grow and even decreases after the menopause has been established. We have here a case in which there is undoubted exception to the above theory.

Case III. That of a young girl aged twenty-eight, who had been suffering with hemorrhages and pain during the last two years. She submitted to various kinds of treatment, electro-puncture among the others, which latter, unfortunately, had produced some difficult adhesions. Examination showed a uterine tumor reaching midway between the pubes and umbilicus. The cicatrices from electro-punctures could be easily felt; both lateral pelvic spaces were painful on bi-manual pressure. The patient was anæmic in the extreme, her hands and finger nails waxy in color and almost transparent. The tumor as it came to sight after incision was made, had the characteristic appearance of a myoma, so much so that my assistant, Dr. Elliston J. Morris, inquired if I was absolutely certain that the patient was not pregnant. The tumor was removed with difficulty, since it had been partially twisted on its axis from left to right, and become adherent in that position, no doubt by the electro-punctures, for the scars were found on that side. With the united strength of my assistant and the screw, we were at last enabled to enucleate it. The left ovary and tube were fixed behind the uterus, while the right appendages were floating free above the pelvic brim.

This case will enable me to show you, very clearly, the formation of a pedicle, which has always been the most interesting and important part of the extra-peritoneal method. The tumor having grown rapidly, its peritoneal covering was thoroughly stretched; it became necessary, after having adjusted the wire loosely, to make a circular incision into the capsule from four to five inches above the line of the nœud. This immediately retreated close to the wire, and the bladder having been drawn up, by the rotation of the tumor, was thus saved from being injured. The operation was soon completed after making the usual toilet of the peritoneum, and taking the peritoneal stitch on each side of the stump. A drainage tube was placed, and the incision closed.

This case again shows an enlarged uterine cavity measuring four inches between the cornua. Some granulations can be seen on the mucous surface.

Case IV.—Is one of unusual interest, of uterine cancer removed through the vagina; interesting from the fact that through the patient's persistent refusal of an operation I have actually seen its devolopment. Three years ago she came to me, suffering from pelvic pain, due to pyosalpinx. I advised an operation to which she submitted, made a good recovery and would hear of no further operation, which was actually called for on the large, unilateral tear of the cervix. She occasionally appeared at my office for local treatment, usually after having had a severe hemorrhage or some pelvic pain. The uterus being freely movable, I knew the pelvic pain was not due to any adhesions. The appearance of the cervix, enlarged, congested and mottled, showed me that I could look for the trouble there. Several weeks treatment, consisting of depletion and tampons, would usually relieve her for as many months, always to be followed by a return of the former appearance and symptoms.

All suggestions of operation for any radical treatment remained unheeded. At one time I succeeded in removing a small portion of the cervical tissue and examined it carefully under the microscope. It showed distinctive cancer cells. The patient again remained deaf to all good advice and I saw nothing more of her for about six months; when she came she reported having had hemorrhages and suffering now from a constant offensive, viscid discharge. She then permitted me to remove the uterus. As you see the uterus has been entirely removed, but the cancerous degeneration seemed to have proceeded on to the right broad ligament. This operation was done October, 1892, the patient is still living, but is no doubt suffering from a cancerous degeneration of one or more of the internal organs; she has a slight inoffensive discharge from the vagina.

This case taught me that early operations will give a better chance to the patient than any other known treatment.

Case V.—Is a case of sarcomatous kidney, removed from a child two years old, August, 1892. It weighed, some hours after removal, 8 lbs. and the measurements were 8¾ by 5½ inches; cicatrix 6½ inches.

The child had the appearance of a

little skeleton straddling a tumor. The operation was done more to relieve the pressure symptoms she was suffering from, thinking she had some abdominal effusion, but it became necessary to remove the kidney after the incison was made and strange to say the child got well. There were many things against which she had to struggle. The operation was done in a four-roomed house in a small street, a railroad about a quarter of a square away with all its accompanying dust and dirt, and the thermometer in the 90's, so that I was placed in a position of choosing between two evils after the operation—to let the child remain in the hot room or to place it in the coach and set it out in the shady places on the street.

There was several interesting points about the operation; one, which necessitated peeling off the adherent bowel resulted in a tear of its mesentric attachment of about six inches in length. This was carefully sutured and a voluntary movement three days after the operation seemed to be painless and had absolutely no sign of blood, proving its union. Urination was voluntary during the first night, with but slight amount of blood present which was probably due to the cutting of the ureter. I have always regretted that I have not had a picture of the child as she was before the operation. Of course there is always a sequel to these operations. One usually looks for a return and it came in this case, although the child became apparently healthy. The return was located in five of the retro-peritoneal glands, also a growth in the pancreas similar to the one on the kidney. The right kidney was slightly enlarged otherwise it seemed normal.

As you will see, this tumor originated in the corticle substance; the pancreas was attacked in the same way. The patient died on December 13th; the return having shown itself three weeks previously.

In a collection of thirty-one nephrectomies for abnormal growths of the kidney occurring in children at or under twelve years of age, we have sixteen recoveries and fifteen deaths, making an immediate mortality of 48.4 per cent.

Of the sixteen there were eight who succumbed to a return of the disease, five at or under four months (one of these at eleven weeks), three at or under eight months. One was reported to have died one and a half years after the operation; cause not stated. In one no return after three months, another after four months, and four not stated.

Tuberculin as a Test for Tuberculosis in Cattle.

Probably few physicians are aware of the enormous practical value in the animal industry of tuberculin; that is to say, if the position taken by the New York and other State Boards of Health regarding it is correct. A gentleman who has a valuable herd of thoroughbred cows writes us that twice within the last six months his herd has been examined by competent veterinarians and pronounced healthy. A third examination, however, with the aid of tuberculin, caused a condemnation of over one-half the herd. He adds:

The New York State Board of Health is killing by the hundred, animals condemned by diagnosis with tuberculin, and the State is paying full value for them. The veterinarian says that the autopsy shows the diagnosis to be correct in every case. He says also that it is impossible for the best veterinarian to discover tuberculosis by physical examination except in extreme cases. My herd is apparently in splendid condition. Breeders do not know of its existence in their herds. They let a cow remain in the herd until she is unquestionably tuberculous and then remove her, but she has then already infected the herd. A temperature of 103° F. condemns the cow. In a herd of Jerseys, at Troy, of eighty head, he has killed thirty-three, and will kill twenty more of them this week. Autopsies are held in the presence of physicians and veterinarians. There have been 15,000 tests with tuberculin in England. New York evidently believes in this kind of diagnosis, and will probably have to pay $500,000 to eradicate tuberculosis. The veterinarian says the State is full of it in herds both of thoroughbreds and common cows.

We understand from other sources that the State Board of Health fully believes in the certainty of tuberculin diagnosis. Through its means it has been discovered that some of the best bred herds, supplying high-priced milk, cream and butter, are infected.—*Med. Rec.*

LARYNGISMUS STRIDULUS FOLLOWING BULLET WOUND IN THE ARM.

J. W. Irwin, M. D., Louisville, Ky.

A few years ago I had under my care a man twenty-two years of age, the son of a hardware merchant, who while handling a pistol one day accidentally discharged the weapon, the bullet entering his right arm just under the anterior border of the deltoid muscle near its insertion, right over the region of the nerves leading down from the axilla. No notice was taken of the bullet, or could it be found, as it was buried under the muscular surface; the external wound healed without any trouble. Four months afterward, he was taken with the most intense form of croup. It was not the season of the year when croup usually occurs. (It looked more like laryngismus stridulus.) I was sent for in the initial attack, and administered remedies with a view of relaxing the condition. Medicines did not seem to have any effect unless I kept him under the influence of chloroform—ether relaxed it even better than chloroform. I treated him several days for this affection of the throat, and I could discover nothing but a spasmodic condition to treat. He could not drink without bringing on an attack; could not change his position, could not laugh, could not talk without bringing on a most intense form of spasmodic croup or laryngismus stridulus.

I knew nothing of his former injury at this time—later he told me that he was shot in the arm some months before; I then began to look for some reflex irritation as the cause of the trouble. Upon inquiry the history as above related was elicited. I made an examination of the wound. Nothing could be seen but a very small cicatrix slightly depressed, and after lifting the muscle from the bone with my fingers, I thought I could feel a little hard substance. I asked him if the bullet had ever been removed, and he stated that the physicion who attended him had never been able to find it. That it occasioned him no trouble up to that time, and so far as he knew the bullet was still in his arm. There was no sensitiveness to call attention to the cicatrix. So far as references to the wound is concerned, the patient did not know he had a bullet in his arm. I then made a further investigation, and found the bullet which had lodged in the deltoid muscle near its insertion. It had become encapsulated, and was about the size of an hazel nut. I at once suggested the removal of the bullet, believing that it might be the cause of the reflex trouble. He accepted the proposition, and the operation was easily and quickly done. The second day after the removal of the bullet, the spasmodic trouble disappeared, and four years afterward it had not returned. I would not have been surprised in that case to have seen epilepsy.

Teacher.—"That is the fourth question you have failed to answer. If you don't study harder, how do you expect to get along when you grow up?"

Little Boy.—"I guess I'll be a schoolteacher, an' when I want to know anything I'll just ask th' class."—*Good News.*

So greatly are the Paris hospitals overcrowded by consumptive patients that a separate hospital has been established for their benefit at Agincourt, by the municipal authorities of Paris.—*Pub. Opinion.*

Wife—"George, which is proper; to say 'Congress meets on Monday,' or 'Congress will meet on Monday?'"

Husband—"Nuther wun, there haint a-goan to be corum!"—*Cleveland Plain Dealer.*

Kept the Cash in the Family.—"Well, the widow sued the editor."

"Get anything?"

"One hundred dollars. But she didn't have it long."

"Why?"

"Editor married her."—*Atlanta Constitution.*

Professor Lombroso, the Italian scientist, concludes after investigation that women of the criminal and immoral type are invariably larger of hand and feet and smaller in the head than average women.—*Pub. Opinion.*

TRANSLATIONS.*

THE ROLE OF THE BLADDER DURING CHILDBIRTH; RETENTION OF URINE.

The form of the bladder in the woman differs from that in the man. Instead of being ovoid with a median distension, it is more flattened from before back and is not symmetrical; its right half is larger than its left. Its base assumes a much greater lateral distension on account of the disposition of the vagina and the pelvic organs in general. This flattening and this enlargement are more marked in the multiparous women than in the primiparæ. Haller admits that this enlargement is due to the pressure which the gravid uterus exercises upon its base. In consequence of repeated pregnancies this lateral expansion will become more and more marked. Barlow attributes this special form less to the effects of the pressure of the gravid uterus than to the movements and the rubbing which the uterus and its appendages exert upon the bladder. Ouimet believes that both causes are active. During the first months of pregnancy, the form and the connections of the bladder change but little. The sinking of the gravid uterus together with its weight, on account of its firm attachment to the posterior wall of the bladder, prevent elevation of this organ distended by urine. Its antero-posterior expansion not being permitted, in proportion as the urine accumulates the bladder can expand only in the transverse diameter. When the uterus on account of its volume is obliged to rise out of the pelvis and to take its place in the abdominal cavity still the same conditions hold; its antero-posterior expansion is always hindered by the uterus; its lateral expansion only is easy. It is at this period, also, that there is produced an alteration in the situation of the urethra. It forms normally a slight curve with its convexity below. If the distended bladder drags itself upward, the curve increases, if it forces itself downward, it diminishes or disappears. There is also a change in the curve in proportion, as the vagina is stretched during pregnancy. At the end of the pregnancy, the capacity of the bladder is, in primiparæ, diminished on account of the low situation of the inferior segment of the uterus and the fetal head, and in multiparæ, quite to the end of pregnancy, the result is similar, although much less marked on account of the sinking of the uterus. In some cases of pregnancy (pendulous abdomen) the bladder may be compressed from above downward, and consequently show a tendency to the formation of a perineal or vaginal hernia. A retention of urine exists then, and a large cystocele appears. At the beginning of labor, important changes may be observed. The urethra is lengthened, and the bladder is elevated above the pubis. This modification in the situation of the bladder is produced in order to avoid a retention of the urine. "The urinary bladder," says Smellie, "in the pregnant woman near to term, is often so pressed upon by the uterus that it can only contain a very small quantity of urine." From a study of the subject of the retention of urine, during and after child-birth, Ouimet has formulated the following conclusions:

1. Retention of the urine during confinement and delivery, may produce results so grave for the mother and child that every accoucheur called to attend to a women at the beginning of labor, should at the first disengaged moment, inquire as to the time that has elapsed since the last micturition and as to the manner in which micturition was accomplished during pregnancy.

2. The accoucheur should not be satisfied with the woman's replies, but should practice a careful examination of the genito-urinary organs.

3. A small quantity of urine retained in the bladder will suffice to cause grave disorders. The bladder should be emptied naturally or artificially, at the time of confinement.

4. If it is always proper to empty the bladder, even in normal confinements it is of the greatest importance to empty it when it is necessary to perform an obstetrical operation—version, the application of the forceps, Cæssrean section, etc. —Ouimet in *l'Union Medicale du Canada*, July, 1893.

—D.

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators M. B. Worner, M. D., and W. A. N. Dorland, M. D.

A CONTRIBUTION TO THE THEORY OF EPIDEMIC NIGHT BLINDNESS.

O. Walter (*Arch. f. Augenheilkund* xxvii) observed in the Ural region, during the years 1889–92, 269 cases of night-blindness; 197 among men and 72 among women. The history of these patients was that there were no prodromal symptoms; the sight was suddenly lost on a certain evening. The disturbance in vision began in the centre of the visual field, spreading centrifugally. Shortly before or after the rise of the sun, the sight again suddenly returned. The grade of blindness in the presence of poor illumination varied in different cases.

Ophthalmoscopically there was in but few cases an appearance of dimness in the region of the papillæ. The duration of this disease was variable, and returns occured in 78.8 per cent.

In places where sanitary conditions were poor, this epidemic occurred early in the spring, and attacked persons of all ages; an increase of numbers being noticed among those who suffered from lack of good sanitation. A deficiency in nutrition could be regarded as a predisposing element, to which could be added certain direct causes. No psychical overexertion or dazzling elements, as some other authors have described, were noticed in these cases; in all miasmatic influences were present.

The treatment consisted in nutritive diet, and internally, cod-liver oil with strychnia. —W.

Abdominal Hysterectomy.

Dr. L. G. Richelot reports (*L'Union Medicale*, 1893) twenty-one hysterectomies with two deaths. Great importance is placed upon the following points in the technique. 1st. The stump is carefully sewed with silk. 2d. A peritoneal flap having been previously prepared, is secured over the surface of the stump. 3d. The stump is carefully seared with the cautery before being covered. Total extirpation of the uterus has not yet received his approbation.—*Centralb. f. d. Med. Wiss.*, No. 45, 1893. —W.

The Dublin Conjoint Examinations.

The returns of the October examination of the Colleges of Physicians and Surgeons in Ireland show a decrease in the number of candidates as compared with last year of 149 to 122. The examination was, on the whole, excessively fatal to candidates, the rejection percentage being 54.0 as compared with 42.2 for the same examination last year. The "mortality" was greatest in the second and third examinations, in which the rejection rates were 60.9 and 63.6 as compared with 38.1 and 58.2 for the same examinations of the same period last year.

The committee recommend to the Colleges:

(*a*) That a numerical system of marks ranging from 0 to 10 be substituted for the "judgment" system at present in use.

(*b*) That a uniform standard of 50 per cent. be the passing mark in all subjects, and in all examinations.

(*c*) That in deciding as to whether a candidate has passed in any subject or not, the marks in all the divisions of the subject—written, oral, and practical—be considered together; provided, however, that bad answering in the clinical portion shall not be compensated for by excellence in the other portions of the subject.

At the Preliminary Examinations held in November and December, the rejection percentage was 44.3, against 47.4 at the same examination last year. The entries were 89 as compared with 96 last year. There seems to be a curious variance in the quality of the candidates at the two examinations of the present year, the rejection percentage of the November examinations have been 57.7, while that of the September examination was only 38.7. On the whole it will be observed that the Irish Conjoint Examinations do not err on the side of softness. Whether it be that candidates are of inferior quality, or that the examination is unpractical and excessively severe, the fact remains that the average candidate runs a better chance of getting through his examinations in either England or Scotland than in Dublin. Neither of the other divisions of the Kingdom show so high a rejection percentage as Ireland.

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SATURDAY, JANUARY 27, 1894.

EDITORIAL.

REORGANIZING A COLLEGE.

The Jefferson Medical College has long sustained a repntation as one of the best medical institutions in the United States, and to-day all things considered it has no superior in this country. The men comprising its present faculty, are worthy successors of those teachers of the past whose abilities created the reputation of the college, and whose fame is inseparable from the fame of Jefferson. Such men as Parvin, Keen, Da Costa, Forbes among the older members of the faculty, are men of world-wide reputation and authority, both as teachers and practitioners. Among the younger members such names as Dercum, De Schweinitz, Hare, Montgomery have more than a local significance and assure the maintenance of its reputation at the same high level that has existed in the past and now exists; and in all probability buds of promise will be developed from among the sucklings of the faculty.

If not always the first to institute movements towards higher medical education, Jefferson has never been the last to adopt improvements. The college has a large and enthusiastic alumni association, which possesses what few such associations do possess, a considerable influence with the powers that manage its alma mater. It was probably due to the influence of this association that the college has recently adopted the four years' course of study to obtain a diploma.

At a meeting held last week, the Association adopted resolutions calling upon the Board of Trustees for further modifications in the organization of the college, which will undoubtedly increase its effectiveness. The first of these calls for the abolition of the fee system of paying the teachers and a substitution therefor, of fixed salaries. Such action would tend to equalize the compensation of the members of the faculty, and would at once cut off the greatest obstacle to enforcing a higher standard of medical education, for the question of increasing or decreasing income would have no weight in considering the fitness of an applicant for matriculation. The require-

ments for admission could immediately be strictly enforced, and if desirable, raised, and would at onee exclude a class of aspiring novitiates, whose presence in an institution of learning can be accounted for only on the supposition that they can pay admission prices. This would at once conserve the reputation of the institution for the quality of its product and for the quantity of its honesty.

A second resolution was adopted, requesting the Board of Trustees to appoint a member of the faculty as prevost, and place in his hands certain high powers and privileges, as for instance, meeting with the trustees, recommending additions, etc., suggesting candidates to fill vacancies. In general, to be an authoritative working-head for this institution, with the extensive powers committed to similar officials in other institutions that we wot well of. The appointment of such an official is fraught with danger to the ultimate success of the institution, even when limiting the power placed in his hands. While placing unlimited power in any one person's hands is practical suicide or slavery. History need not be searched for examples to prove this statement. Nor are the causes of disaster hidden from view. The centralization of power is of benefit up to the point where it places definitely responsibility for the exercise of powers, but when carried to an extent that makes power autocratic, responsibility practically ceases and the exercise of power implies slavery on the part of all coming within its province.

Of course it will be claimed no such absurd proposition has been made, and that there is no intention to establish a dictatorship. Neither did the fabled tailor intend to admit the entire camel when he allowed him to put his nose in the door. The advantages of a working head for an institution are obvious, but the disadvantages of that head becomimg swelled are sufficiently great to deserve consideration. If great power is to be entrusted to any one person, he must be possessed of certain characteristics to perform the duties required of him. His individuality must be decided enough to enable him to formulate a definite policy. His executive ability must be great enough to successfully carry out his policy. He must combine the wisdom of the serpent with the harmlessness of the dove. He must be all things to all men. He will receive the support of the authorities that established his position—at least he will receive it at the outset, later on he will compel it. The greater his ability to fill the position, the greater danger is he to the final success of the institution.

Among the eminent men constituting the faculty of Jefferson College, we doubt there is one who, placed in such a position, could command the hearty support of his peers in the faculty. Dissensions invariably arise among men seeking the same end, but thinking for themselves. Where the will of the one is paramount, obstacles to his policy must be removed, and opponents retire, or suffer the infliction of an emeritus position. Policy will not allow a recurrence of like opposition if preventable, and the dictator installs a puppet of his own in the vacant position. The dictator's position is thus strengthened at the direct expense of the institution. Retirement is the fate of every man who presumes to think for himself and has the courage of his convictions.

A medical college in pantomime, whose puppets dance at the bidding of any one person, is a sorrowful spectacle for the last decade of the Nineteenth century.

A one-man medical college is always a 'one-horse' institution.

THE REPORTER is interested in this matter in as far as the cause of medical education in Philadelphia is concerned, and it begs to commend to its Jefferson friends that saying of Demosthenes: "The end of wisdom is consultation and deliberation.

THE MEDICAL BUCCANEER.

Before the days of steam-ships, and indeed until the early part of the present century, the high seas were everywhere infested by bands of pirates in quest of prey.

When they sighted a prize they set sail straight for it, and when the attack was ordered no quarter was asked and none given.

Those daring characters have always been painted by historians in the blackest colors. But after all, they were not without a redeeming trait, for, when captured they expected no mercy. They were a thousand times more manly than the modern, *medical* buccaneer.

To talk of amending codes, or instituting reforms, or improving the status of the profession while this insatiable gormand is allowed unfettered liberty is a travesty on reason. He plays his part in manifold ways. He often roams in high places, and may even wear a professor's gown. He looms up at medical conventions and indeed, may even be an author of no mean position. He is always clamoring for reform; he wants to reform the code, let down the bars and clear the way so that his pilfering career may be unhampered. His neighbor stands in mortal terror of him, because, he well knows, that should he be required to call him in consultation, the new arrival would quickly oust him and cooly take possession himself. He performs impossible operations and always cures every case, and the unsuspecting, simple-minded, honest plodder, as he reads his statistics, is quite overcome with amazement and admiration. He has a sneaking way of advertising. To go into the regular column of the quacks, would be to mix with the common herd; moreover it is highly expensive; therefore he has himself *interviewed*, or one of his helpers will see to it that, while the great man speaks, full stenographic notes are taken and the thing, highly colored, will be spread broad-cast in the early morning press.

The drag-net of the pirate is so far spread out, that he leaves almost nothing for the honest plodder. From year to year he becomes more and more bold, and finally, having duped and bulldozed his professional brethren, he turns his attention to lay people before whom his hideous hypocrisy is supported by comsumate strategy. He wants to raise funds for a ward "for the poor, you know," run *soirees*, parties, etc., until a necessary sum is wrung out of the pockets of the unsuspecting. Then he suddenly blooms out a specialist, and now that he is safely entrenched behind his own walls, in his zeal for patients his audacity is villianous, for through the mails, he is a constant intruder, incessantly appealing to practitioners to send to him that which they themselves depend upon for their living.

Let every independent, self-respecting member of the profession rise and stamp out this scorpion. He is the bane, the curse and blight of a profession, which without him has a career of usefulness and prosperity before it.

The Effect of Urine, Normal and Pathological, on the Heart.

Lusini (*Arch. di Farmacol. e Terap.* Fasc 19, 20, 21, 1893) has studied the effects of normal urine when applied direct to the heart of the frog or toad, comparing it with that produced by the urine of jaundice, tuberculosis, nephritis, scarlatina, measles, and pneumonia. He concludes as follows: (1) Normal urine always causes an increase in the extent of the individual heart beats. (2) The urine passed in disease produces peculiar toxic effects directly proportional to the increase of urea, salts, colouring matter, extractives, etc., as well as to the abnormal matters contained in such urine. (3) The urine of infective disease is far more toxic than that of other common maladies; this appears to be due to the amount of leucomaines found in such urines.—*Ex.*

ABSTRACTS.

RUBIDIUM IODIDE IN SKIN DISEASE.

Dr. Leo Leistikow, of Hamburg, who at the suggestion of Unna, made trials with rubidium iodide at his clinic, reports (*Monat. f. prac. Dermat.* Vol. xvii, No. 10) as follows:

In all cases a five per cent. aqueous solution of rubidium iodide was used, three tablespoonfuls of which were given daily.

Case 1:—Mrs. S., aged 45 years, suffers from two specific ulcers of the hard palate. The ulcers were first cauterized with a ten per cent. solution of chromic acid for three days. After this rubidium iodide was administered internally. Under this treatment the ulcers healed completely in two weeks.

Case 2:—Mr. M., aged 30 years, has a gumma which is located in the *sulcus retroglandularis*. Restoration takes place by external application of a gutta-percha plaster mull containing mercury and carbolic acid, and with a 3 weeks' internal treatment of rubidium iodide.

Case 3:—Mrs. A. I., aged 55 years, is affected with an extensive ulcerating syphilide of the right lower thigh, accompanied by varices of the veins. The treatment consists of bandaging the leg with zinc oxide-ichthyolglue, and prescribing rubidium iodide internally. Restoration results within 14 days.

Case 4:—Mrs. A. H., aged 40 years, suffers from gummatous periostitis of the frontal bone, and besides presents an insufficiency of the bicuspid valve. Rubidium iodide effects a cure within two weeks without influencing the action of the heart.

Case 5:—Mr. R., aged 20 years, shows the first general symptoms of secondary lues; besides specific angina and universal papulous syphilides, extremely violent headaches prevailed. An eight days' inunction-treatment makes the secondary eruptions disappear, but without relieving the headache. Internal treatment with rubidium iodide in double doses for three days caused the headache to disappear entirely.

Case 6:—Mr. M., aged 30 years, who is suffering from secondary syphilis, had just undergone an inunction-treatment and desires to take iodine. He is given rubidium iodide for two days, but owing to violent conjunctival catarrh, this remedy had to be discontinued.

Case 7:—Mr. J., aged 41 years, is afflicted with acute polyarthritis of gonorrhoic origin. By a two weeks' treatment with rubidium iodide he is entirely cured. Appearance of a iododerma pustulosum.

Case 8:—Mr. M., aged 60 years, presents a gumma of the tongue. At first potassium iodide is administered and effects considerable shrinkage, but after eight days produces a violent catarrh of the upper respiratory tract. Potassium iodide is therefore discontinued and substituted by rubidium iodide. This change of treatment causes the symptoms of catarrh to diminish, and after four weeks' use of the rubidium iodide the gumma is healed.

It is especially important to note, that in the one case of syphilis complicated with valvular disease, the heart's action was not in the least influenced by the rubidium iodide. Altogether the rubidium salts have no toxic effect upon the heart like the potassium salts. It is advisable, therefore, to employ rubidium iodide in all cases where the use of potassium iodide is contra-indicated on account of its dangerous effect upon the heart. The symptoms of iodism (the iododerma and the catarrh of the mucous membranes) are not excluded by the use of rubidium iodide. On the other hand, whenever iodism follows the use of Iodide Potassium, these unpleasant accompanying effects may be avoided by the employment of rubidium iodide. Gastric disturbances were never observed. The taste of the rubidium salt is not as disagreeable as that of potassium iodide.

PROFESSOR GARNER has returned from Africa and declares that he has learned, beyond doubt, that there is a monkey language, and it can be learned by man.—*Pub. Opinion.*

CONTRIBUTORY NEGLIGENCE OF PATIENT AS DEFENSE TO CHARGE OF MALPRACTICE.

One of the most interesting decisions rendered for some time in a malpractice case, is that of the Appellate Court of Indiana in Young v. Mason (decided November 22, 1893, and just reported, 35 Northeastern Reporter 521). In this case the jury returned a general verdict for $1,000 in favor of the party claiming injury, and also returned answers to forty interrogatories submitted on behalf of the physician sued. Now answers to interrogatories override a general verdict when both cannot stand together, but not where they can be reconciled.

It was clearly shown by the answers in this case that the physician possessed fair and ordinary knowledge and skill, also that the manner in which he dressed and treated the injuries of this patient was, with one exception, such as is approved and followed by the most skilful surgeons in that vicinity, and which is approved by the standard authors and text writers upon the subject of surgery. The exception was that the answers did not conclusively show that he exercised due skill and care in reducing a fracture near the wrist joint. This act, with other acts of alleged negligence, it was charged caused a certain stiffness of joints and a loss of the use of the arm, for which damages were sought. But the answers also showed that the patient took her injured arm out of the sling, contrary to directions, and placed it on her lap, window sill and table, and that she also refused to allow the physician to use passive motions at the times, and to the proper extent.

Indulging every reasonable presumption and intendment in favor of the general verdict, and granting that the party who brought the action established to the satisfaction of the jury every fact put in issue, except when the answers to the interrogatories affirmatively and conclusively shown to the contrary, and giving a fair and reasonable construction to the facts, which were clearly, specifically, and without conflict or contradiction found in the answers, the court concludes that the negligence of the physician in failing to reduce the fracture near the wrist, and the refusal of his patient to allow him to subject the injured joints, at the proper times, to passive motion, concurring in producing the injuries for which recovery was sought.

The authority of other courts is quoted to the effect that "the law has no scales to determine in such cases whose wrong doing weighed most in the compound that occasioned the mischief." "It is the duty of the patient to submit to the treatment prescribed, and to follow the directions given, provided they be such as a physician of ordinary skill would adopt or sanction . . . A person cannot recover from another for consequences attributable in part to his own wrong."

The law on this very important subject is further illustrated and summed up, by the Appellate Court, as follows: Suppose a man fractures the bones in his leg below the knee, and calls a surgeon to treat the injuries, and the surgeon negligently fails to properly reduce one of the fractures, but in all other respects gives proper treatment, and the patient, in disobedience of the directions of the surgeon, negligently removes the bandages used as a part of the proper treatment by the surgeon, or is otherwise guilty of contributory negligence, and such combined negligence of the surgeon and patient unite in producing a shortness and stiffness of the leg, for which injuries an action is brought against the surgeon, can the patient recover? The patient is certainly not responsible in such case for the original negligence of the surgeon in failing to properly reduce the fracture, but this negligence of the surgeon unites with the subsequent contributory negligence of the patient in causing the shortness and stiffness of the leg. Now it seems clear, under such circumstances, and the authorities cited, that the patient can not recover for the consequent shortness and stiffness of the leg.

Where both the surgeon and patient are free from negligence, or where the surgeon is free from fault and the patient is guilty of negligence, no recovery can be had against the surgeon in any case. It is only where the surgeon is guilty of negligence and the patient is without negligence on his part contributing in any degree to such injuries that the patient can recover damages of the surgeon,—*Jour. Amer. Med. Ass.*

SOCIETY REPORTS.

THE LOUISVILLE CLINICAL SOCIETY.

Meeting, November 7, 1893.

ALOPECIA AREATA.

DR. I. N. BLOOM: No. 1—This patient, a young man about twenty years of age, as you will see is suffering from alopecia areata. The feature of greatest interest in the case is the extent of the disease. I think it is safe to say that at least one-half of the hair is gone. He is a young man of exemplary habits, no suspicion even of specific trouble. He has been under my treatment for only a short time, but there is already considerable improvement. I believe in about four to eight weeks the hair will cease to fall out and the new pigmented hairs will appear. Lanugo hairs can be seen in spots, and here and there on the older patches pigmented hairs show up.

I have a lady under treatment at the present time where the disease is about one-half as great in extent as in the case before us.

EXTENSIVE CASE OF PSORIASIS.

No. 2—This is a plain case of psoriasis, the most extensive, I think, that I have ever seen in private practice. The surface of the entire body is affected, the spots varying from the smallest patch to the size of your two palms. It is because of the unusual extent rather than the unusual disease that I exhibit the patient. He has been under my treatment about a week, and this is the second attack in which I have seen him. The first attack was about two years ago. The treatment has been simply tar; I have also given him iodide of potassium, following out the line of treatment of Chopp and Kotzen, who claim to have gotten good results from large doses of iodide potassium in these cases. He takes thirty-five drops, containing 30 grains of iodide, at a dose three times daily. As a local application I have used 10 to 20 per cent. ointment of oleum rusci. Arsenic is recommended, but this is the slowest method of treatment; it would require about twenty weeks in a case like this. Under iodide of potassium and tar I believe a cure can be effected in six to ten weeks. The extent of surface affected in this case makes me chary of using chrysasobin. Investigations embracing several hundred cases prove that iodide of potassium has absolutely no ill effect on the blood; that it does not increase or diminish the red blood corpuscles. In this connection I wish to say that I have administered in a case of brain syphilis what I believe to be the largest dose of iodide of potassium ever given in Louisville—540 grains daily. All symptoms disappeared in six weeks.

DISCUSSION.

DR. A. M. VANCE: I remember a case of alopecia I saw when a student where there was absolutely no hair upon the head. It was in the clinic of Dr. Lunsford Yandell at the University. The patient was a boy ten years of age, whose head was as clean as a billiard ball, except the very fine hair that Dr. Bloom speaks of which could be seen only upon the closest inspection. I remember the treatment, particularly how successful it was—at each sitting an area of probably about two inches square was painted with pure carbolic acid and before over one-half of the extent of the scalp had been gone over, the hair began to grow upon the portion that had been first painted. The ultimate result in this case was perfect. The effect when the hair commenced to grow was very noticeable, as it was black.

DR. W. O. ROBERTS: The case of alopecia shown by Dr. Bloom recalls one which a number of the members of this society have seen. His scalp looks very much like the case before us. The patient has been under the care of many doctors, myself included, and among other things used in the case has been carbolic acid, but I could see no benefit from anything that was done for him. I lost sight of the patient for a number of years and a few days ago met him on the street; his head looks now about the same as it did the last time I saw him.

The other case shown by Dr. Bloom is of great interest to me; it is the most beautifully marked case that I ever saw. The patient has post-cervical enlargements, and this leads me to ask Dr. Bloom if he has ever had syphilis.

DR. A. M. VANCE: The so-called psoriasis due to syphilis is not often as extensive as this. I would like to ask Dr. Bloom if he simply takes the history of the case, or are there other ways of differentiation.

DR. I. N. BLOOM: You do not need any history at all in these cases. As this patient appears to-night it is scarcely a fair case: He has been under treatment for a week and the appearance of the spots has changed very materially. Had you seen the patient a week ago when he applied to me for treatment, with the characteristic silvery scales all over his body, you would have made diagnosis of psoriasis without any possible difficulty. As I have already stated two years ago I cured this patient of a similar attack of psoriasis, at that time the spots were only about one-fifth as abundant as now, varying in size from your thumb nail to a silver dollar. There is no syphilitic psoriasis that resembles any other psoriasis, except the so-called psoriasis palmaris syphilitica. In making the diagnosis between the three palm dis-

eases, syphilis, psoriasis and eczema, it is sometimes very difficult and you may have to take the history into consideration. But, generally speaking, a close examination of the eruption on the body will generally suffice. In the previous attack which the patient had, he was treated locally with chrysasobin and the effect was all that could be desired. At that time he received nothing internally.

DR. T. P. SATTERWHITE: Is there any eruption on the hands of the patient?

DR. I. N. BLOOM: No, nor is there any on his feet.

DR. T. P. SATTERWHITE: Is it not a fact that attacks of this character are almost always considered the result of syphilitic involvment?

DR. I. N. BLOOM: No, sir, never.

DR. T. P. SATTERWHITE: Is there any connection between this trouble and gout?

DR. I. N. BLOOM: No, sir.

DR. A. M. VANCE: What is the supposed etiology?

DR. I. N. BLOOM: It is not known. All we know about it is that in the vast majority of cases it occurs before or about the time of puberty. That at times heredity seems to play a part. I am accustomed to say to my patients that I can cure them of the eruption in from four to eight weeks, depending upon the extent of the disease but it may return in six weeks, six months or six years, or never. I have patients who have not had a return of the trouble for thirteen years; in others it has returned in a year; some in six months; in the case reported it has been two years, I prepared him for this, however; my prognosis is very conservative in all such cases. It is a very common disease, but is rarely found as wide in extent as this case shows.

MALIGNANT DISEASE OF THE RECTUM.

DR. W. O. ROBERTS: I had a patient come here to-night with view of showing him before the society, but the gentleman whom I wished especially to see the case is not present, therefore I will not introduce the patient. I believe it to be a case of malignant disease of the rectum. I wanted to show it because of the fact that it is the third case that has come under my observation in which the disease is not advanced too far for operative interference. All of the other cases which have come under my observation have gone too far for any operation to be considered. The rule is if the cancerous growth extends higher up than you can reach with the finger, it is beyond all operation looking toward a cure of the disease. This trouble is located in the lower end of the rectum and confined to the posterior wall; an ulcerated surface which does not seem to cover a space larger than a nickel. Above and to either side of the ulcerated surface two nodules can be plainly felt. The man complains of pain in defecation and for a short time afterward, and passes mucous, pus and blood, as he describes it, with each stool. I saw him for the first time to-day; I feel satisfied that it is an epithelioma and a very favorable one for removal.

I recall to mind now a case of cancer of the rectum in a lady whom I saw soon after the trouble began. This is one of the cases where I thought operation would be followed by good results. Dr. Mathews also saw the case in consultation and concurred in my diagnosis. This patient was operated upon in St. Louis, some ten years ago and she seems to be in perfect health now.

DR. L. S. MCMURTRY: I have here a group of specimens which I have selected from a series of abdominal sections done within the last few weeks which may be of interest.

HYDROSALPINX.

No. 1.—This is a tumor of the broad ligament, an accumulation of serum in the Fallopian tube. It was very difficult to remove without rupture on account of adhesions. The Fallopian tube you will see is distended with serum, and the ovary is in the broad ligament and not incorporated with the cyst. The fimbriated extremity of the tube you will observe is sealed upon one end of the cyst, and the other end is included in the ligature placed there. It is a hydro-salpinx. The specimen is interesting in its relations to sterility.

TUBO-OVARIAN DISEASE OF LONG STANDING.

No. 2.—Here are two specimens from the same patient of tubo-ovarian disease of long standing. The patient had suffered repeated attacks of peritonitis, and had been an invalid for several years. The ovary and Fallopian tube are so amalgamated as to appear as one mass. On cutting into this mass, after removal, a cavity containing a dark soft material is found, which would doubtless have advanced to abscess.

CYSTIC OVARY.

No. 3.—This is another specimen of tubo-ovarian disease. The operation was done yesterday morning and the specimen is quite fresh. It is a case of cystic ovary with adhesions and involvement of the adjacent Fallopian tube. The disease was bilateral, and illustrates a very severe lesion which is comparatively rare in pelvic inflammatory disease. The cyst contained a dirty, bloody fluid, consisting of decomposed blood and serum. These blood cysts are among the most dangerous of this class of tumors, and are associated with extensive inflammatory lesions. The adhesions were universal.

SUPPURATING DERMOID CYST OF OVARY WITH TWISTED PEDICLE.

No. 4.—This specimen is a very typical il-

lustration of dermoid cyst of the ovary. For some time preceding the operation the patient suffered intensely with active inflammatory symptoms, as you will see the cyst was suppurating. You will observe that the pedicle was twice twisted and is very small. The tumor was very generally attached by adhesions to the intestine and parietal peritoneum. On opening the tumor it is found to contain sebaceous matter, hair, and other material characteristic of these tumors. The surface of the sac is very dark, the result of low vitality from interference with the circulation through the pedicle in consequence of the twisting. These tumors require the utmost care in their removal, as the foul contents of the tumor must be carefully prevented from obtaining contact with the peritoneum.

FIBROID TUMOR OF THE UTERUS.

No. 5.—This is a specimen of fibroid tumor of the uterus. I have had the patient under observation at times for several years. Four years ago it was very small and was producing considerable hemorrhage. At that time I opened the abdomen and removed the uterine appendages, hoping to obtain the same good result from this operation that I have witnessed in a large number of similar cases. The patient was much improved for a time, but the tumor steadily grew and inflicted upon her much pain and distress. She was a frail woman, and in consequence of pain and hemorrhage her health was much impaired. Nervous and other complications came on in time and she was sent from home by her family physician for general treatment, with the hope of improving her general health and relieving the nervous disturbances which were of most serious character. I had not seen the patient to examine her for over two years when I was asked to see her two weeks ago, and found the tumor to have reached these extensive proportions.

Her physician had for some time advocated an operation for entire removal of the growth, and the patient was anxious for anything which promised relief. Her health had failed rapidly of late months, and her sufferings were intense. Several severe attacks of peritonitis during the past year had added to her distress. Her complexion was very bad, her general nutrition impaired, and her sufferings had made her dependent upon daily doses of morphia. The operation was the most difficult of the kind that I have ever undertaken. The tumor was firmly packed and fixed by organized adhesions to every portion of the pelvis. I had literally to dissect it out. The bladder was dissected off of the tumor in front, the rectum was released behind, the utmost care was required to protect the ureters; and the difficulties were increased by a cystic degeneration and suppuration of one portion of the tumor. The operation was completed very satisfactorily at last, and the patient was put to bed in very fair condition considering her extremely feeble condition. On examining the specimen the suppurating portion will be observed. Members of the Society will recall a number of large tumors of this kind that I have presented here from time to time, several of them much larger than this one, but in comparison their removal was easy. The patient never fully reacted from the operation and succumbed two days later.

In all the other cases here illustrated recovery was easy and prompt. Indeed in no one of them did any untoward symptoms arise.

DISCUSSION.

DR. W. H. WATHEN: I wish to say a word concerning two of the specimens exhibited by Dr. McMurtry: The specimen exhibited as a hydro-salpinx is a typical small parovarian cyst. The tube is pervious and healthy, and the cyst is below it.

The dermoid cyst is a pretty specimen of one of the varieties of dermoid conditions that are often met with in practice. No one can tell positively that a tumor is dermoid until it is removed and the specimen examined. I have removed dermoid tumors looking exactly like an ordinary ovarian cystoma, but upon critical examination discovered only a bunch of hair to demonstrate the dermoid origin.

DR. W. O. ROBERTS: In regard to the hydrosalpinx: Several weeks ago I operated upon a young girl fifteen years of age for radical cure of an irreducible inguinal hernia, left side. Upon opening the sac I found the ovary with a hydrosalpinx. As the ovary was found to be in an unhealthy condition, I removed it, together with the tube. The tumor had existed ever since the patient was quite a young child and she wore a truss strange to say, but always had to take the truss off during menstruation, and her sufferings were so intense during that time that she had to go to bed for at least two days. She has menstruated once since the operation with scarcely any pain at all, and her recovery has been uneventful.

DR. T. P. SATTERWHITE: With reference to the fibroid tumor, I want to report one case showing the tenacity of life and one of the complications of operations for the removal of growths of this character. Some years ago I assisted Dr. McCoy of Jeffersonville, Ind., in removing some fibroids from the uterus of a patient; the largest one was about the size of an orange, with three or four smaller ones. I was asked to see the patient again in the course of a month, and the abdomen was enormously distended, inflammation had set up; upon reopening the abdomen we drew off it seemed to me a gallon of pus—the abdomen was divided by adhe-

sions and the pus had accumulated above. Notwithstanding this, the patient lived over a month and then died. I do not remember how many days she lived after the inflammation and formation of pus. The operation was laparotomy.

Dr. Cheatham read a paper on

CHRONIC RETRO-BULBAR NEURITIS.

(See page 90 in last week's issue.)

DISCUSSION

DR. T. C. EVANS: Tobacco and alcoholic amblyopia afford a striking instance in which the clinician anticipates the work of the pathologist. Von Graffe in 1866 and Leber in 1869 called attention to the pallor of the temporal half of the optic disc; this in conjunction with the central section led them to conjecture that the amblyopia was the result of a retro-bulbar neuritis. This opinion was confirmed pathologically by Samelsohn and others in 1880 and 1882. They found the pathological condition to be an interstitial sclerosing inflammation—in many respects similar to hepatic cirrhosis. The process involves the pappillo-macular group of fibers and may occur at any point from the nerve head to the chiasm. A few years ago Dr. Uthoff, of Berlin, examined ophthalmoscopically one thousand inebriates in the various asylums—he found the white sector of the disc in 14 per cent. of the cases, a much larger proportion than had hitherto been supposed. I think it not unlikely that similar sclerosis occur in other parts of the nervous system. Most of the cases occurs in those addicted to both alcohol and tobacco. In those using only tobacco the smokers are the ones usually affected.

A case recently came under my observation where the man did not smoke and did not chew excessively, yet he seemed to have a typical case of tobacco amblyopia. His vision when he came to me was reduced to 20 cc.—I advised him to leave off tobacco entirely and put him on strychnia and phosphorus; in a few months his vision came up to 20 xx.

DISPLACEMENT OF SEMI-LUNAR CARTILAGE BY INJURY—REMOVAL—RECOVERY.

DR. A. M. VANCE: A young man, a footballist, consulted me some time ago with the history that about a year ago while playing football and making a "stand," I believe they call it, sustained an injury to his knee, "put his knee out of joint," as he called it. He said that it was pulled back and he went on with the game. A number of times he had the same accident, and every time applied the same remedy. Three or four months before he consulted me he began to suffer with pain of a boring character over the head of the fibula, with tumefaction. A week after I first saw him the pain and swelling had increased, and I then thought I could detect an abscess of the cold variety, and incised it. I found the contents to be not only fluid, but considerable caseous material also came out. The cavity of the abscess was thoroughly irrigated, but the pain continued and there was not the improvement I had hoped for. I then increased the size of the incision and removed what I took to be a floating cartilage from the knee joint. Entire recovery soon took place. I feel sure that the body removed was the semi-lunar cartilage.

DISPLACEMENT OF SEMI-LUNAR CARTILAGE BY INJURY—REPLACEMENT BY PRESSURE.

DR. W. O. ROBERTS: Several weeks ago I saw a young man who had his knee injured in a game of football. He claimed that a man in the process of the game had struck him on the inner side of the leg between the knee and the ankle, and at the same time another one hit him on the outer side of the thigh, twisting his leg out at the knee-joint. He says it was replaced and he was taken home; while on the way there it was again knocked out and again replaced. I saw him twenty-four hours after receipt of the injury and the knee was enormously swollen, but as well as I could make out the bones seemed to be in perfect position. The leg was put up in plaster dressing which was not disturbed for ten days; when the plaster was removed the swelling had disappeared, and on the outer side of the joint there was quite a protuberance which I thought at first was the result of lateral displacement of the knee, but upon careful examination and measurement became satisfied that it was not, but that it was one of the semi-lunar cartilages displaced. Under chloroform by extension of the leg, and pressure upon the protruded cartilage much to my surprise it slipped in. I feel satisfied in this case that it was one of the semi-lunar cartilages. The plaster dressing is still on, and I am a little inclined to believe there will possibly be a recurrence of the trouble upon the slightest twisting of the knee.

IODIDE POTASSIUM IN CEREBRAL SYPHILIS.

DR. I. N. BLOOM: I had supposed that a a few months ago in speaking of the use of iodide of potassium in cerebral syphilis, I had given the largest dose ever administered in Louisville—540 grains per day. It seems that Dr. Roberts has given a larger amount, and I would like to have him tell us something about the case.

DR. W. O. ROBERTS: The case has already been reported. It was a case of brain syphilis which I saw with Dr. Bodine. Iodide of potassium was administered in gradually increasing doses until the patient received one-half ounce three times per day, a total of 720 grains daily.

CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE AMERICAN JOURNAL OF OBSTETRICS for January contains a paper by Dr. Howard A. Kelly on

The Direct Examination of the Female Bladder with Elevated Pelvis—The Catheterization of the Ureters under Direct Inspection, with and without Elevation of the Pelvis.

After reviewing the results obtained by others in this field, the author describes his own method by which, he states, any gynecologist, after a little practice, should be able in almost every case to catheterize either ureter within a few seconds after the introduction of the speculum. The following list of instruments and accessories is given by the author as required for the examination: female catheter; a series of urethral dilators; a series of specula with obturators; common head mirror and lamp, Argand burner or electric light; long, delicate mouse-toothed forceps; suction apparatus for completely emptying the bladder; ureteral searcher; ureteral catheter without a handle; several bran bags or an inclined plane for elevating the pelvis. A valuable aid for the beginner searching for the ureteral orifice is the following: A point is marked on the cystoscope five and a half centimetres from the vesical end, and from this point two diverging lines are drawn toward the handle with an angle of sixty degrees between them. The speculum is introduced up to the point of the V, and turned to the right or left until one side of the V is in a line with the axis of the body; then by elevating the endoscope until it touches the floor of the bladder the ureteral orifice will usually be found within the area covered by the orifice of the speculum. The ureteral orifice can often be found by an adept at once, and almost instinctively, by a single movement of the speculum after its introduction into the bladder. The author states that an anesthetic is not necessary for cystoscopy or catheterization of the ureters, unless the urethra is to be dilated up to No. 14, 15, or 16. In nervous women it is often best to make a thorough examination first under anesthesia. Subsequently a satisfactory illumination of the bladder can be made and the ureters catheterized and any ordinary treatment applied through the number ten speculum without anesthesia. A pledget of cotton saturated with a five per cent. cocaine solution, inserted into the urethra seven minutes beforehand, greatly facilitates the dilatation and is often the best form of anesthesia. The author believes it is the duty of the surgeon to examine at once all bladder affections which are more than trifling, to disclose at the exact nature and extent of the disease. The procedure is also of use in defining the ureters in hysterectomy for carcinoma and in some hysteromyomectomies. The paper is illustrated by cuts of the instruments and photographs showing the method of applying them. The article is an amplification of a former paper by the author entitled "My Recent Ureteral Work," published in *The Annals of Gynæcology and Pædiatry* for May, 1893, and reviewed in the issue of THE MEDICAL AND SURGICAL REPORTER for May 27, 1893.

Dr. Philander A. Harris contributes a paper on

A Method of Performing Rapid Manual Dilatation of the Os Uteri, and its Advantages in the Treatment of Placenta Previa.

The author believes that the employment of rapid manual dilatation must be restricted to cases of advanced pregnancy where, for any reason, it is desired to effect prompt delivery. Its use presupposes the possibility of the full introduction of the index finger to its largest diameter without much delay or difficulty. If with the patient anesthetized, the index finger cannot in a very few minutes be fully introduced, he would seriously doubt the possibility of successful employment of this or any other manual method of dilatation, and would advise the operator, for the time at least, to cease further attempt. The author's experience with his particular method is limited to seven cases of placenta previa, six cases of crossed birth, and two of eclampsia. The method advised by the author is as follows: The index finger is introduced up to its largest diameter with the os. If the forefinger be now withdrawn till only the tip engages, it will generally be found that the tip of the thumb may be introduced alongside the finger. When the tips of both index finger and thumb are thus within the ring, and the second finger sharply flexed, with the os resting on its palmar and outer aspect, we have but to keep the index and second fingers close together to form a notch from which the os-uterine ring cannot easily escape. This the author terms the first position. The straightened and extended thumb, resting on the outer lateral side of the index finger, is now carried as far from the tip of the index finger as the enlargement of the os will permit. Considerable power for dilatation may indeed be exerted by continuing this movement of the thumb, but a far greater and far less fatiguing force may be exerted if we implant and immovably hold the thumb on the index finger whilst forcibly and together flexing the index and second fingers. When a little headway has thus been gained, we slightly extend the index and second fingers, which will permit the thumb to travel further from the tip of the index finger, at which point we again press and hold the extended thumb firmly against the outer side of the index finger. In this position the holding point is again taken, whilst tonic flexion of the index and second fingers continues the work of dilatation. After a while the fingers are again slightly extended, which will permit the

thumb to be carried still further toward the metacarpo-phalangeal articulation. Whilst holding it firmly on the index finger, flexion of the index and second fingers should be renewed. If tonic flexion of the fingers has been steadily maintained, we shall now be able to introduce the index and second fingers and thumb. The relation of the extended thumb to the first finger is maintained as before, while the os, encircling the thumb and also the two fingers, rests on the dorsal surface of the more sharply flexed third finger, in the same manner as it rested on the second finger before. The power for stretching is derived from fixation of the thumb on the first finger while counter-pressure is effected by flexing the index, second, and the third fingers. In a short time we shall have dilated sufficiently to permit the introduction of the third finger. The os, still hooked over the tip of the extended thumb, will now have its point of counter-pressure between the third finger and the inner latero-dorsal aspect of the fourth finger. Tonic flexion of all the fingers is again resorted to, and the gain taken up by occasional slight extension of the fingers and movement of the extended thumb toward the metacarpo-phalangeal articulation. Gradually, in this manner, the thumb and all four fingers are introduced. Here again the enlargement is effected by flexion of all the fingers, although the index and second will be flexed far less than the third and fourth fingers. This, the author terms, the fourth position, and states that the limit of dilatation in this position for a hand measuring seven and three-quarter inches over the metacarpo-phalangeal articulation (as measured for gloves) is eight and a half inches (circumferential measurement). The extreme limit of possible and easy dilatation with the hand in this position will not exceed the glove measurement more than one inch, which is scarcely sufficient for the easy introduction of the whole hand. He then resorts to what he terms the fifth position, in which the os is made to encircle the first row of phalangeal bones of the fingers, and the second or last phalanx of the thumb. The movement required in this posision is extension of all the fingers, the tips of the fingers being at the same time flexed to lessen their encroachment on the intra-uterine space. A less fatiguing and somewhat more powerful dilating manipulation (which the author terms the sixth position is effected by causing the os to encircle the second row of phalangeal bones of the fingers and the first phalanx of the thumb. In either of the last two positions the degree of circumferential dilatation possible will exceed the above glove measurement by at least three inches. This, of course, is a much higher enlargement than is required for the introduction of the hand into the uterus. The author states that there is neither call for dragging down, or pushing upward of the os; it is dilated *in situ*, while the encroachment on the intra-uterine space is reduced to a minimum by flexure of the tips of the fingers in all the stages of every position. Any normal hand, he thinks, should endure the fatigue consequent on the accomplishment of rapid dilatation, if dilatation is possible. Having once failed to accomplish rapid dilatation, owing to the impossibility of introducing the first finger, the author reminds his readers that it may not be possible to effect dilatation by this method. Appended to the paper is the report of cases in which the author made use of his method. The paper is illustrated by cuts showing the position of the fingers throughout the steps of the manœuvre.

Dr. X. O. Werder reports a case of

Pregnancy Following a Partial Suprapubic Hysterectomy Complicated by Hemorrhage Through the Abdominal Cicatrix.

Previous to operation the patient had been subjected to the application of electricity after Apostoli's method for two months, fifteen applications in all, varying from one hundred to one hundred and fifty milamperes. This treatment neither affected the size of the tumor nor did it produce the slightest symptomatic improvement, so that the patient clamored for operation. The tumor was attached by a very broad and thick pedicle to the posterior and right surface of the fundus of the uterus. The base of the tumor was encircled by an elastic ligature, above which the pedicle needles were passed, and the tumor removed above this point. The uterine cavity had not been opened, though subsequent events proved that part of the uterine tissue had been included in the ligature. The pedicle was fixed in the lower angle of the wound in the usual way. Pedicle and ligature came away on the twentieth day and the patient left the hospital about six weeks after the operation with a small fistulous opening at the bottom of the abdominal wound. She missed the second period after the operation and developed symptoms of pregnancy. At the end of the fourth month there was a copious hemorrhage from the fistulous opening, which by this time had become enlarged from internal pressure to the size of a half-dollar, the amount of blood lost being at least a pint according to the estimation of the patient. There were seven hemorrhages in all, five of which were profuse, producing marked anæmia of the patient and causing a great deal of anxiety as to the ultimate result. Labor began three weeks before the expected time and the first stage was very slow. Labor was terminated by forceps. During labor there was only a slight oozing from the fistulous opening. The child was living but was very small and thin. The placenta was found adherent just under the fistulous opening and required manual separation. At this place the hand in the uterus noted an apparent absence of the uterine wall, and the placenta seemed to be attached to the abdominal wall around the external sinus. The abdominal wall was extremely thin, as could easily be ascertained by the hand placed over it and pressing against that in the uterus. Patient made an uninterrupted recovery. The reporter states that there is no doubt in his mind that the slough under the elastic ligature extended into the body of

the uterus and on separating opened into the uterine cavity; and that there was a direct communication between the fistulous opening in the abdominal wound and the uterine cavity, which allowed some of the menstrual blood to escape through it at her menstrual period; and that, furthermore, the source of the hemorrhages during pregnancy was the placenta itself, the upper edge of which was attached immediately under the bleeding surface.

The principal points in the case described are:

1. The menstural discharge through a small fistulous opening remaining after a partial supravaginal hysterectomy, which communicated with the cavity of the uterus.

2. Pregnancy occuring eight or nine weeks after operation in a woman previously sterile, in spite of a utero-abdominal fistula.

3. Pregnancy terminating in the delivery of a healthy though poorly developed child, at or at least near, the end of her term, in spite of a firm and unyielding fixation of the uterus to the abdominal wall, and in spite of frequent and profuse hemorrhages, from the placental site, through a sinus opening in the lower angle of the abdominal cicatrix.

Dr. H. Meek reports

A Case of Tubal Pregnancy With Some Peculiarities.

The peculiarities consisted in:

1. Situation above and in front of the uterus, between it and the pubes, the usual situation being behind the uterus.

2. The uterus being retroverted behind mass and on the same side instead of being displaced to the opposite side.

3. The intermittent contractions, which were so like contractions of the pregnant uterus as to lead one to think it a case of pregnancy in one horn of a double-horned uterus.

After examining the literature at his disposal, the reporter comes to the conclusion that the situation of the tube sac, above, in front, with the uterus back and on the same side, is unique.

No flushing or drainage was used at the operation. The patient made an uninterrupted recovery.

Dr. A. Brothers discusses

The Present Position of the Electrical Treatment of Extra-uterine Pregnancy.

The author finds that twenty-five cases which he has been able to trace were doing well after a lapse of one to eight years, and that none of them had been compelled to undergo secondary operations. Many of these patients still carry traces of the old trouble, but without perceptible inconvenience. The author analyses the literature on the subject, presenting a table of cases treated by electricity. He finds that only one death—that of Jauvrin's patient—has occurred in seventy-eight cases in which electricity was employed without puncture, and in this case there were marked symptoms of hemorrhage previous to the resort to electricity. Of the seven cases treated by electro-puncture, there were five recoveries and two deaths. This proves that electro-puncture is a very dangerous method. The bad results being undoubtedly due the puncture and not to the current.

Dr. W. S. Christopher, presents

A Plea For the Study of Pediatrics.

It is the author's opinion that every reputable medical school should appoint a full professor of pediatrics. This professor should include in his lectures and clinics not only a discussion of the diseases of children, but, so far as time will permit, he should impress upon his class the wide scope of the subject and elicit an interest in its development. He should use his influence with the faculty to establish in the school a study of the fundamental branches upon which his own is dependent. Thus in anatomy he should secure the dissection of infants and the study of embryology in a properly equipped laboratory. In physiology and chemistry he should secure the laboratory work on the chemistry of food stuffs, the processes of digestion, assimilation, and elimination. In pathology the morbid anatomy and bacteriology of early life should receive formal attention.

Dr. Andrew F. Currier contributes an article on "Myoma Uteri and Its Treatment." [An abstract of this paper appeared in *The Annals of Gynæcology and Pædiatry* for November, 1893, and was reviewed in the issue of THE MEDICAL AND SURGICAL REPORTER for December 2, 1893.—ED].

The remaining papers in this issue are: The report of "The First Symphysiotomy in America," by Dr. Wm. Thomas Coggin; the continuation of the paper by Dr. Anna M. Galbraith on "Poliomyelitis Anterior Acute Infantilis;" and a paper by Dr. Flanklin H. Martin on "Ligation of the Broad Ligaments of the Uterus for Uterine Fibroids," with the report of the author's sixth case. The operation was a complete success.

THE MASSACHUSETTS MEDICAL JOURNAL

for January contains a paper by Dr. D. J. Kelley on

Tubercular Meningitis,

reporting a case. The patient was a little girl of nine years, the child of healthy parents. The first symptoms were noticed about three weeks before the doctor's first visit and consisted of nothing more than a gradually increasing hebetude and sleepiness accompanied by a slight headache at the vertex. No impression was made on the patient by any treatment and she gradually sank, toward the last refusing all food. The temperature was taken daily; there was no increase until twenty-six hours before death when it rose to 99½°. The pulse although very weak, was always regular and never more than 90, until the last two days, when its frequency rose to 140 shortly before death, which occurred quietly, without the least struggle, ten days after the doctor's first visit. There was no paralysis or paresis; no convulsions; no papillary or visional disturbances at any time; nothing but a constantly increasing headache and sleepiness from the beginning of the attack to the dissolution of

the patient. The following is the report of the post mortem:

Removing the calvaria no adhesions were noticed between the dura mater and the bone. The dura mater itself was very tense, and slight adhesions along the longitudinal fissure could be readily observed between it and arachnoid. The tubercular character was at once manifested on the removal of the dura mater. The tubercular granulations were moderately sprinkled on the whole convexity of the brain, especially along the sylvian fissures. And where the tubercles were most abundant a very slight amount of lymph could be seen. Removing the brain and examining the base the same was noticed; the tubercles, however, existing in greater abundance, and lymph had been thrown out in greater quantity, especially over the central portion of the base, the optic commissure, and the pons. The vascularity of the brain was well marked. The ventricles were filled with a large amount of clear serum and the tubercles were largely disposed over the choroid plexus.

Dr. E. A. Lewis discusses

Rigidity of the Os Uteri,

reporting a case. The patient was twenty-nine years old, plethoric habit, and in her first confinement. The doctor first saw her after she had been sixteen hours in labor. He found that the waters had been escaping gradually since the first hour of labor; pains frequent and very lancinating. Having waited three hours, and finding the os not inclined to dilate, the author prescribed an opiate, and directed the vagina to be syringed with a tepid antiseptic solution. Two hours later there had been no improvement. Three one-grain doses of opium were given at intervals of an hour without effect. Extract of belladonna was also applied to the os without result. After the woman had been eighteen hours in labor the author decided to resort to operative measures. By careful manipulation the index and middle fingers were introduced within the os, and it was thus expanded to the extent of two inches in diameter. Owing to the exhausted condition of the woman, the author decided to terminate the labor at this point by the use of the forceps. A living nine-pound chid was delivered, the mother made a good recovery. The author advises the employment of the above treatment in cases of rigidity of the os. The author speaks of an experience of seven cases in which he practiced the method and delivered five living children; all the mothers made a good recovery. He advocates the early resort to the forceps in such cases. When rigidity is confined to the os and neck, caused by some former organic disease of these parts, the treatment must necessarily be somewhat different. Should there be any hardened cicatrix of the os, the result of former ulceration or inflammation, incision of the cervix may be necessary.

Dr. Frederick Wallace Abbott contributes a paper on

The Antipyretic Value of Hot Water used Externally.

Its use is especially recommended in those cases of enteric fever characterized by a cool surface, feeble cutaneous circulation, and marked depression, where the thermometer will disclose a very high temperature showing a determination of blood to the great vessels and internal organs. The class of cases in which hot water may be profitably employed, the method of its application, and the auxiliary measures to be adopted, must be determined at the bedside. Broadly speaking, however, the young, the old, the debilitated, and those of a nervous temperament, are most benefited by the hot-water treatment, although its use is by no means restricted to these. As to the method of using hot water, this must be adapted to individual needs, the facilities at hand, and, as most of us sadly realize, the notions of the family and neighbors. In the treatment of meningitis, the exanthemata, and other febrile conditions in the young, we put the little patients into a warm bath, and gradually add hot water till the desired temperature is reached. A sense of comfort will be immediately experienced, and the patient may fall into a quiet slumber while in the bath. The bath should not last over fifteen minutes, when he should be gently rubbed dry, wrapped in a blanket, and returned to bed. If cardiac weakness exist, a little stimulant may be administered just before the bath; and, though held to be contraindicated in cases of fatty heart and atheroma of the great vessels, the author has yet to see any ill attend this treatment. The process may be repeated several times during the day, the guide to its frequency being the benefit derived. If it be deemed inadvisable to employ the hot bath, much good may be had from frequently sponging the entire surface, and hot cloths profitably be applied to the head, spine, and chest. Many who shrink from the application of cold water, and are even injured by it, will derive much satisfaction and benefit from hot sponging, and request its frequent repetition; and an antipyretic agent of no mean value is offered, the author believes in this treatment.

The remaining paper in this issue is by Dr. R. E. Anderson, entitled "Medicine as Practiced by the Lower Animals." In it the author points out the remedies selected by the sick animal, such as the various grasses.

Lysol in Obstetric Practice.

Israelson (*St. Petersburg med. Woch.*, No. 47, 1893) urges the use in obstetric practice of lysol as having greater antiseptic properties and a less poisonous action than any coal-tar derivative hitherto known. He uses a 1 per cent. solution for the skin, etc., and a 2 per cent solution for instruments, this preparation being less milky than the former. No pains, but only slight burning sensations are produced by the use of either, and it has no irritant action on the skin. Owing to lysol forming a "lather" with water it is a substitute for soap, rendering unnecessary the inunction of the hands and the application of soap and water prior to operations. The author has tried lysol extensively during one year and a half with satisfactory results.

PERISCOPE.

IN CHARGE OF WILLIAM H. BRICKER, M. D., B. SC.

MEDICINE.

Catrin on Observations upon Mumps.

The author has made a careful analysis of 159 cases and concludes as follows:

1. Mumps being indifferently upon either side: generally the parotid swelling begins as unilateral, affecting the other side after a lapse of from several hours up to five days.

2. Prodermic symptoms are the rule. In sixty-two out of a hundred cases there is at the same time an inflammation of the pharynx.

3. In twenty-four cases out of a hundred there is an initial fever, ordinary slight, but it may rise to 40°C., and last four days.

4. The prognosis as to complications is not determined either by the degree of severity of the glandular swelling or the intensity of the pain.

5. In half the cases the submaxillary glands participate in the process.

6. The duration of the treatment should be at least fifteen or twenty-five days.

7. The disease attacks especially young men serving in the army.

8. It is evidently contagious, but the germ is easily resisted, and prolonged exposure is necessary to infection.

9 The period of incubation appears to be about fifteen or twenty days. Relapses are more common than generally believed as they occur in about 6 per cent. of cases.

10. A distinction must be made between the true orchitis of mumps and the simply testicular injection which is never followed by alteration in gland structure.

11. Among other complications may be cited rheumatism, otitis, localized œdema, endocarditis, albuminuria, and purulent orthritis.—*L'Union Medicale.*

Harley (Vaughn) on Diabetic Coma.

After recounting his experiments in the production of artificial coma in dogs by the introduction of sugar into the circulation, Harley describes the coma as: 1. A stage of nervous irritation, which may be so severe as to assume the form of an epileptic convulsion, or so mild as to appear in the form of mere trembling of the skin. 2. A comatose stage which may merely amount to a few hours' drowsiness or extend to a deep coma from which the animal cannot be roused, and ending in death.

The cause of the preliminary nerve irritability stage is probably due to the formation of some as yet undetermined substances acting as an irritant to the nerve-centres, the comatose stage being in its turn due to the effects of various toxic substances combining to produce it. The coma seems to be principally due to a diminution in the alkalinity of the blood produced by the acid products derived from the breaking up of the sugar molecule, the acids combining with the sodium carbonate and bicarbonate as well as with the ammonia in the blood, and thus hindering the blood carrying the carbonic acid to the lungs for elimination; while there is at the same time a diminution in the oxygen absorbed, and thus the oxidation in the organism is hindred from being properly carried on by a process of tissue asphyxia.

The artificial coma produced in the writer's experiments, while it is exactly analagous to that occurring in diabetic patients, does not appear to depend upon an increase in the quantity of the sugar in the organism, but upon the increase that has taken place in its derivatives. In all probability the same products are being continually formed in the health body, but only in such small quantities and so gradually that they are either sufficiently rapidly eliminated or there is sufficient time for them to be further transformed, in the process of metabolism, into harmless substances, and consequently are never present in the blood in an amount capable of producing coma.

In the cases of diabetes due to diminished assimilation of the sugar in the organism, such as pancreatic diabetes, coma occurs when the sugar has disappeared from the urine. From some cause as yet undiscovered the normal power of breaking down the sugar molecule in the ordinary processes of metabolism has been regained, and since the quantity of sugar present both in the tissues and the blood had been previously increased, an excess of its products is produced, and hence the coma. This point is of practical importance, as it indicates that one ought always to be on the outlook for coma, whenever a diabetic patient's urine ceases to contain sugar, if its disappearance cannot be accounted for either by dietic or other treatment. By analyzing the urine and finding acetone, or aceto-acetic acid, as well as making quantitative estimation of the ammonia and the lactic acid in it, one may be able not only to predict the outset of coma, but prevent it.

The rational treatment founded on the results obtained from the experiments is to administer alkalies. If the symptoms are urgent and time is of moment, sodium carbonate might be administered subcutaneously or intravenously, the pulse being carefully watched in case of heart failure. At the same time, since there is so great a diminution in the oxygen absorbed, it is advisable to encourage oxidation. The inhalation of pure oxygen may help, as well as trying to improve oxidation by massage. Diuretics together with large quantities of fluid hasten the elimination of the toxic products derived from the sugar.—*Brit. Med. Jour.*

On the Restriction and Prevention of Tuberculosis.

The committee appointed by the American Public Health Association, in conjunction with the International Congress of Public Health, has published the following report:

1. Tuberculosis has been conclusively demonstrated to be contagious, by bacteriological experiments, by clinical observations, and by a study of the history of the disease.

2. Tuberculosis is a preventable disease. Its preventability follows as a logical sequence upon its contagiousness, but has likewise been demonstrated in a practical life.

3. The contagium of tuberculosis resides entirely and solely in broken-down tubercular tissue. A person suffering from tuberculosis, therefore, does not become a source of danger to others until he begins to give off broken-down tubercular tissue, either in the form of sputa from the throat or lungs, diarrœal discharges from the bowels, or matter from a tuberculous sore, such as lupus, white swelling, cold, abscess, scrofula, or tubercular inflammation of a joint.

4. A person suffering from tuberculosis can be made entirely harmless to those about him by thorough sterilization of all broken-down tissue, immediately upon its being given off. With proper precautions it is, therefore, possible to live in the closest relationship, and upon the most intimate terms, with consumptives, without contracting the disease.

5. Tuberculosis is not hereditary. A predisposition to the disease can be transmitted from parent to offspring, but this is more true of tuberculosis than it is of all other contagious diseases.

6. A predisposition to tuberculosis can be created anew by malnutrition, or by anything which depresses the nervous system.

7. Tuberculosis affects animals as well as man, and is identically the same disease in both. In domestic life human beings and animals mutually infect each other.

8. The media through which human beings are ordinarily infected by animals are milk and meat.

9. Houses in which consumptives have lived, and in which immediate sterilization of all broken-down tissue has not been practised, are infected houses, and are liable to convey the disease to subsequent occupants.

10. Spitting upon floors and into handkerchiefs, and permitting the broken-down tissue to dry and become pulverized, is a prolific cause of spreading tuberculosis.

11. Temporary occupation of hotel rooms, sleeping car berths, and steamer cabins by consumptives in the infectious state, can infect them so as to convey the disease to subsequent occupants, unless proper precautions are taken against contamination of the bedding, furniture and walls with booken-down tubercular tissue.

We recommend the following practical measures for the prevention of the disease:

1. The notification and registration by health authorities of all cases of tuberculosis which have arrived at the infectious stage.

2. The thorough disinfection of all houses in which tuberculosis has occurred, and the recording of such action in an open record.

3. The establishment of special hospitals for the prevention of tuberculosis.

4. The organization of societies for the prevention of tuberculosis.

5. Government inspection of dairies and slaughter houses, and the extermination of tuberculosis among dairy cattle.

6. Appropriate legislation against spitting into places where the sputum is liable to infect others, and against the sale or donation of objects which have been in use by consumptives, unless they have been thoroughly disinfected.

7. Compulsory disinfectants of hotel rooms, sleeping car berths, and steamer cabins which have been occupied by consumptives, before other persons are allowed to occupy them.—*N. Y. Med. Record.*

Koster (H.) on the Treatment of Erysipelas.

During the past year Koster has treated about fifty cases of erysipelas with local application of white vaseline. A moderately thick layer of vaseline is applied with a brush over the affected area aud over the surrounding healthy skin. Over this is laid a piece of ordinary linen, or, in case the face is affected, a linen mask with openings for eyes, nose, and mouth. The dressing is held in place by a gauze bandage. Fresh vaseline is applied twice daily and the same saturated mask is again laid over it and bound down. The results were exceedingly favorable, being quite as good as those obtained by painting with iodine, ichthyol, or corrosive sublimate-lanoline. In most cases the fever fell by crisis in a few days, usually two or three; pain and tension diminished rapidly, and relapses were not more frequent than under other treatment. The success of the treatment was sometimes surprising. The area of inflammation did not increase in most cases. Good results were obtained on the scalp without removing the hair. The method of treatment is recommended by its simplicity and freedom from dangerous or irritating properties.—*Centralblatt f. Klin. Med.*

Hysterical Œdema.

W. Gajkevicz (*Gaz. lekarska*, No. 39, 1893) reports the following case: A girl, aged 18, previously quite healthy, suddenly noticed a swelling of her right upper extremity, but, as no pain or redness or rise of temperature was present, she paid no attention to it. After three weeks, pain of a localized character set in the swollen extremity; the right leg also became painful, and after a short time the patient lost her voice. She was well nourished, and the organs of circulation and respiration, and the kidneys were normal. The right arm was 2 to 4 centimetres thicker than the left; not painful; no "pitting" on pressure, pale, with a temperature of 33°C. (as against 35°C on the left), and greatly increased secretion of sweat. Pricking with a needle did not cause bleeding in the right arm, but was followed by a rather obstinate urticaria. During the seven months she stayed in the hospital the right breast and right leg down to the knee also became œdematous. The absence of any disease of the heart and kidneys, and the presence of nervous disturbance, determined the diagnosis of "hysterical œdema."

GYNECOLOGY.

Wyhe (W. Gill) on Dysmenorrhœa and Chronic Endometritis.

Undue importance has been attached to retroversion, and other displacements as the direct cause of symptoms. Displacements simply complicate disease, and may give rise to pain, which, however, is due less to the displacement than to other conditions.

When the broad ligaments are thickened, and the tubes and ovaries diseased, pain will be experienced, as the subject assumes the upright position, even when there is no displacement from the downward pressure exerted upon the fixed uterus and diseased ovaries. When the uterus is healthy, displacement causes but little trouble.

If retroversion exist, next determine whether the case be complicated by disease of the endometrium, or by salpingitis.

If disease of the tubes and ovaries be present, the only procedure is their removal. We cannot treat disease of the Fallopian tubes by curetting and draining. We cannot reach the seat of disease except by laparotomy.

If no such complication exist, boro-glyceride tampons should be placed twice a week between the menstrual periods—but pessaries have no place in treatment.

If such treament fail to effect involution and improved circulation, and the introduction of the sound cause bleeding, or pain, then douche, curette, and drain, making a simple application—never one that will destroy the mucous lining with its deep seated glands and follicles, leaving a scar that will do more harm than good in after life.

As to the curetting, the sharp instrument only is worthy of use. The blunt copper wire currette may turn up the granulations, but will not remove them, leaving behind a better nidus for sepsis than before the dilatation. When there are large pieces of tissue to be removed, blunt and rounded forceps are to be used.—*Internat Jour. of Surg.*

OBSTETRICS.

Zabala (L.) on Resuscitation of the New-Born.

The instrument suggested consist of two parts, the catheter and the ball. The catheter is metallic and curved in one half whose end fits to the shape of the infant's glottis, with one hole on the outside for the passage of the air. The curve of the catheter is regulated by the convexity of the floor of the mouth. The exterior end is straight and adapted to one opening of the elastic ball. This ball is made of soft rubber, and has two openings, one with a metallic aperture, to receive the outer end of the catheter, and the exterior to allow the entrance of the air. Its capacity is calculated to answer to the inspiratory capacity of a new-born's lungs, thus avoiding the risk of their over-distending.

The infant in Sylvester's position, or better still, in a pail of hot water, as in De Forest's. After cleaning the fauces with my fingers wrapped in a cloth, I enter the mouth again with my bare left index pressing the tongue till I feel the epiglottis; I go as far as filling the cavity of the glottis with the point of the finger. Once there, I hold my catheter and carry it to the larynx, when I push the end straight into its cavity. I keep it in place with my left hand, while with my right I fix the empty ball to the outside and I next produce a movement of aspiration that answers very well for the purpose of emptying the new-born's trachea and bronchi of all foreign substances that may have lodged there. I clean, then, the ball and apply it empty again until I believe that the respiratory passages are totally free, and not until then do I force the air into the lungs. The movement of the insufflator ought to be made at the rate of from fifteen to twenty times to the minute and continued with hope of success as long as the beatings of the heart are not totally extinct.—*Loth. Cal. Practitioner.*

ARMY AND NAVY.

U. S. ARMY, FROM DECEMBER 31, 1893, TO JANUARY 20, 1894.

The extension of leave of absence granted Captain Charles E. Woodruff, Assistant Surgeon U. S. Army, is further extended one month and twelve days.

Leave of absence for two months, on Surgeon's certificate of disability, with permission to leave the Department of Dakota, is granted First Lieutenant Charles F. Kieffer, Assistant Surgeon U. S. Army.

Leave of absence for one month, on Surgeon's certificate of disability, is hereby granted to Major Edward B. Mosely, Surgeon U. S. Army.

NEWS AND MISCELLANY.

The Medical Society of the State of New York will hold its eighty-eighth annual meeting February 6, 7, and 8, in the City Hall, at Albany.

Communications relating to the presentation and reading of papers should be addressed to the business committee *prior to the 1st day of February*. Dr. Henry Flood, Elmira, N. Y.; Dr. L. Bolton Bangs, 31 East 44th St., New York City; Dr. Edward Clark, 271 Franklin St., Buffalo, N. Y.

The faculty of the Medico-Chirurgical College, of Philadelphia, has erected three new clinical chairs, viz: Genito-urinary surgery, orthopedic surgery and otology. These together with the vacancy in the chair of clinical medicine will be filled permanently at the end of the present session.

CHEKAN

IN THE TREATMENT OF

WINTER COUGH

Dr. Murrell, of the Royal Hospital for Diseases of the Chest, London, states as follows:

"Myrtus Chekan I have tested in fifteen cases of chronic bronchitis, all the patients with one exception being men. The age of the woman was 51; the ages of the men ranged from 36 to 58. They were all bad cases, most of them of many years' duration. Many of them had been attended at the hospital for some considerable time, and almost without exception they had in former years undergone much medical treatment with comparatively little benefit. Their occupations exposed them to cold, and wet, and draught, and in some instances they had the additional disadvantage of working in a dusty atmosphere. They complained chiefly of paroxysmal cough, with thick, yellow expectoration, and much shortness of breath on exertion. On physical examination of the chest, emphysema was detected, with or without a little rhoncus of the bases behind. *They were, in fact, ordinary cases of winter-cough.* The fluid extract of Chekan was ordered in two-drachm doses in a little water every four hours, the dose being usually increased at the expiration of a week to half an ounce. The medicine was always taken without difficulty. In all cases the patient obtained some benefit, and in most instances the relief was very marked. There was in a few days a decided improvement in the cough, expectoration was from the first easier and soon diminished in quantity, and finally the dyspnœa was less."

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